MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

09175

CERTIFICATE OF DEATH

Reg. Diat. No. 234

1. PLACE OF DEATH:

County Prince Georges

City or town Jenkins Corner (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Jenkins Corner (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Robert Wilmer Allen

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1898

8. AGE: Years 48 | Months 2 | Days 0 | If less than one day hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Peter Allen

13. Birthplace Maryland

MOTHER 14. Maiden name Louise Clay

15. Birthplace Maryland

16. Informant Rubie Ketchel

Address 5497-3rd Ave. S.E. Forestville

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 24-1946 (month) (day) (year)

Cemetery or crematory Bells M. E. Cemetery

Location Camp Springs, Maryland

18. Funeral director Thomas F. Murray

Address 2007 Nichols Ave. S.E. Washington D.C.

18. Sept 24 1946 (Date rec'd by registrar) Howard I. Bracy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22 1946, at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to Cardio-vascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Deputy medical Examiner James D. Boyd M. D. or other

Address Forestville Md. Date signed 9-22-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09176

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince Georges

City or town: Cheverly (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Prince Georges

City or town: Mitchellville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Beall, Emma

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: Louis Beall

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 1900

8. AGE:

Years	Months	Days	If less than one day
46			..... hrs. ..... min.

9. Birthplace (Town, county, and state)

10. Usual occupation: H.W.

11. Industry or business

MOTHER FATHER

12. Name: Oliver Disney

13. Birthplace: Md.

14. Maiden name: Emma Wagner

15. Birthplace: Md.

16. Informant: Mr Louis Beall

Address: Mitchellville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 30th 1946 (month) (day) (year)

Cemetery or crematory: Friendship Cemetery

Location: Anne Arundel Cty Md.

18. Funeral director: H. H. Chambers Co

Address: Riverdale Md.

19. 9/27 1946 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 27 1946 at 3:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 19 1946 to Sept 27 1946 and that I last saw h[illegible] alive on Sept 27 1946

	DURATION
Immediate cause of death: Right Lobar Pneumonia	8 days
Due to: Hemorrhagic Infarct middle lobe right lung	3 days
Due to:	
Other conditions: Mitral Stenosis	6 yrs
Arteriosclerosis	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: See above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James E. Tasser M. D. or other

Address: Upper Marlboro, Md. Date signed 9-27-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

09177

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince Georges

City or town: Cheverly (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 hr - 51 min

Hospital, Institution, or street address where death occurred: Prince Georges General Hospital

How long in hospital or institution? 1 hr 51 min

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Prince Geo.

City or town: Baldwin (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Baby Boy Beam

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	—

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 17 1946

8. AGE: Years | Months | Days | If less than one day: 1 hrs. 51 min.

9. Birthplace: Cheverly, Prince Geo., Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Charles Henry Beam

FATHER — 13. Birthplace: McDowell Co. W. Va.

MOTHER — 14. Maiden name: Bessie Baldwin

MOTHER — 15. Birthplace: McDowell Co W. Va.

16. Informant: Bessie Beam

Address

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 9/18/46 (month) (day) (year)

Cemetery or crematory: Prince Georg's General Hospital

Location: Cheverly, Md.

18. Funeral director: A. N. Beasley, Superintendent

Address: same

19. 9/20 1946 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/17/ 1946, at 4 o'clock P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/17 1946 to 9/17 1946

and that I last saw him alive on 9/17/46 1946

Immediate cause of death	DURATION
Prematurity	
Due to: Atelectasis (failure of respirations)	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Thomas A. Christensen M.D. M. D. or other

Address: College Park, Md. Date signed 9/18/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

09178

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince George's
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 Mo's - 28 da's
Hospital, institution, or street address where death occurred:
113 - 4th. Ave. Takoma Park.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 113 - 4th. Ave. - Takoma Park
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: JUDY BEST.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	S.

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June - 14 - 1946

8. AGE: Years: 2 Months: 28 Days: If less than one day: hrs. min.

9. Birthplace: Georgetown Hospital. D.C.
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name: William Best.
13. Birthplace: Monte Co. Md.

MOTHER
14. Maiden name: Ethelene Tine
15. Birthplace: Suburbia Alabama.

16. Informant: William Best.
Address: 113 - 4th. Ave Tak. Park

17. Burial. (Burial, cremation, or removal. Which?) Date thereof SEPT. 12, 1946. (month) (day) (year)

Cemetery or crematory: Neilsville, Md.
Location

18. Funeral director: J. Richard Walters.
Address: 254 - Carroll St. Tak. Park.

19. Sept 11 1946 (Date rec'd by registrar) James Devey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 11 1946, at 8:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 10 1946, to Sept. 11 1946, and that I last saw h.E.R. alive on Sept. 10 1946.

Immediate cause of death: Extreme Malnutrition (Wt. 4 lb. 4 oz.) 3 m. old. — DURATION: 2 months

Due to:

Due to:

Other conditions: Premature type baby, poorly developed. (over)
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. A. Thomson M.D.
M. D. or other
Address: 113 - Carroll St. Tak. Park. Date signed: Sept. 11. 46

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

This baby has been in Childrens Hosp. & Work. for 2 mo. It was taken to Johns Hopkins Hosp. last week. sent home parents told nothing could be done. I was called in emergency. Child was moribund.

W. A. Shoemaker M. D.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-a)

CERTIFICATE OF DEATH

00179 Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Pr. George
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 mo. 8 days
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 8 mo. 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Pr. Geo.
City or town: Berwyn
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Baltimore Blvd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Beesley, Miss Elizabeth

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F		

6.(b) Name of husband or wife:
6.(c) If alive, give age: 84 years

7. Birth date of deceased (mo., day, yr.): March 2, 1862

8. AGE: Years	Months	Days	If less than one day
84			hrs. min.

9. Birthplace: New Zealand (town, county, and state)
10. Usual occupation: —
11. Industry or business
FATHER 12. Name: John P. Beesley
13. Birthplace: England
MOTHER 14. Maiden name: Jean
15. Birthplace: England
16. Informant: Mrs. Ada Knox
Address: Berwyn, Md.
17. Buried (Burial, cremation, or removal. Which?) Date thereof: Sept 7 1946 (month) (day) (year)
Cemetery or crematory: St. Johns
Location: Beltsville Md
18. Funeral director: F. Gaschis Sons
Address: Hyattsville Md
19. 9/6 1946 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-5- 1946 at 2 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-28 1946 to 9-5 1946 and that I last saw h. alive on 9-4-46 19..

Immediate cause of death	DURATION
Carcin - Vascular Renal	
Phlegm	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Albert Leff M.D. M. D. or other
Address: Hyattsville, Md. Date signed: 9-5-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

09180

CERTIFICATE OF DEATH

Reg. Diat. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: Glenn Dale, RURAL
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 10 mo's, 17 days
Hospital, institution, or street address, where death occurred:
Glenn Dale San. (1 yr., 10 mo's, 17 days)
How long in hospital or institution? ↑

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 439- 21st., N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: BLACKMON ROBERT C., JR.

3.(b) Social Security Number: 577-01-7708

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Mildred E. Blackmon
6.(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): July 28, 1910

8. AGE: Years	Months	Days	If less than one day
36	2	–	...hrs. ...min.

9. Birthplace: Kershaw, South Carolina
(Town, county, and state)

10. Usual occupation: pullman porter

11. Industry or business: –

FATHER
12. Name: Robert C. Blackmon, Sr.
13. Birthplace: Kershaw, So. Carolina

MOTHER
14. Maiden name: Adeline Belton
15. Birthplace: Kershaw, So. Carolina

16. Informant: deceased
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 9-27-46 (month) (day) (year)
Cemetery or crematory: to Wash. DC
Location:

18. Funeral director: Robert G. McGuire
Address: 1920 - 9th St. N.W.

19. Sept 27, 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-27 1946, at 3:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-10 1944, to 9-27 1946
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	2 Yrs
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D., M. D. or other
Address: Glenn Dale, Md. Date signed 9/27/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21a)

CERTIFICATE OF DEATH

09181

Reg. Dist. No. 234

1. PLACE OF DEATH:

County Prince Georges

City or town Jenkins Corner (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Jenkins Corner (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George Ward Blaine Sr

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Widowed

6.(b) Name of husband or wife Gertrude Blaine

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 23, 1865

8. AGE: Years 81 | Months 8 | Days 6 | If less than one day hrs. min.

9. Birthplace Penna. (Town, county, and state)

10. Usual occupation Retired water tender

11. Industry or business U.S. Govt.

FATHER 12. Name George Ward Blaine

FATHER 13. Birthplace Penna

MOTHER 14. Maiden name unknown

MOTHER 15. Birthplace unknown

16. Informant Thelma Blaine

Address Clinton, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 2 - 1946 (month) (day) (year)

Cemetery or crematory Washington Natl Cemetery

Location Suitland, Maryland

18. Funeral director Thomas J. Murray Funeral Home

Address 2007 Nichols Ave S.E. Washington D.C.

19. Sept 29 1946 (Date rec'd by registrar) Edward J. Beall Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1946 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute congestive heart failure	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Deputy medical Examiner James D. Bond M. D. or other

Address Forestville Md Date signed Sept 29 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(107)

CERTIFICATE OF DEATH

09182

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Pr. Geo. Hosp
City or town: Laudon - md (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: md County: Pr. Geo. Co.
City or town: Laudon (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Susie Boland
3.(b) Social Security Number

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): May - 15 - 1873

8. AGE: Years: 73 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace: Va (Town, county, and state)
10. Usual occupation: None
11. Industry or business
FATHER 12. Name: John Boland
13. Birthplace: Va
MOTHER 14. Maiden name: Susan L. McConbille
15. Birthplace: Va
16. Informant: Mrs Glenroy Rodgers
Address: Laudon - md
17. Buried (Burial, cremation, or removal. Which?) Date thereof: 9-14-46 (month) (day) (year)
Cemetery or crematory: ~~1400 Chapin St. N.W.~~
Location: ~~Wash. D.C.~~ Lynchburg Va
18. Funeral director: W W Chambers Co
Address: Riverdale md
19. 9/14 1946 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 14 1946, at 6:50 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-3 1945 to 9-14 1946
and that I last saw h.er alive on 9-13-46 19

Immediate cause of death: Bronchopneumonia Terminal — DURATION 3 Days
Due to: cerebral arteriosclerosis senile degenerative changes — 3 yrs
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: John P. Cann M.D. (M. D. or other)
Address: Hyattsville Md
Date signed: 9-14-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (64)

CERTIFICATE OF DEATH

09183

Reg. Dist. No. 237

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: Aquasco Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month
Hospital, Institution, or street address where death occurred: Aquasco, Md
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prince Georges
City or town: Aquasco, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Earl Thomas Buckler, Jr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 1 1946

8. AGE: Years —; Months 2; Days 9; If less than one day: 21 hrs. min.

9. Birthplace: LAPLATA HOSPITAL, LAPLATA, MD.
(Town, county, and state)

10. Usual occupation: INFANT

11. Industry or business

FATHER
12. Name: Earl Thomas Buckler
13. Birthplace: Hughesville, Md

MOTHER
14. Maiden name: Lynn Lorraine Keech
15. Birthplace: Aquasco Md

16. Informant: Earl Thomas Buckler
Address: Hughesville, Md. Aquasco

17. (Burial, cremation, or removal. Which?) Date thereof: Sept 2 1946 (Month) (day) (year)
Cemetery or crematory: St Mary's Cemetary
Location: Bryantown Md

18. Funeral director: Eugene Gumes
Address: Aquasco Md

19. Sept 12 1946 (Date rec'd by registrar) Mrs Henry B. Carter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 11 1946, at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Respiratory Failure	History is of Immediate Respiratory Failure
Due to: Cause undetermined	
Due to: (possible enlarged Thymus from history)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ... Injured at work?

23. SIGNATURE: Alfred R. Lapin M.D. M. D. or other
Address: Aquasco Md Date signed: Sept 11 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Bra)

CERTIFICATE OF DEATH

09184

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince Georges

City or town: Fairmount Heights (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Innocent

Hospital, institution, or street address where death occurred: 5400 Sheriff Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Fairmount Heights (If outside city or town limits, write RURAL and give nearest town)

Street No. 923 - Eastern Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Stephen Ralph Butler

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Alberta Butler

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): 1880

8. AGE: Years: 66 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Bryan Town, Md (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER — 12. Name: Stephen R Butler

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Christella Mack

15. Birthplace: Maryland

16. Informant: William T. Butler

Address: 210 Walter Place S.E. Washington D.C.

17. (Burial, cremation, or removal. Which?) Removal — Date thereof (month) (day) (year): Sept. 9, 1946

Cemetery or crematory: Washington D.C.

Location:

18. Funeral director: F Gaschè Sons

Address: Hyattsville, Maryland

19. (Date rec'd by registrar) 9/9 1946 — Amanda Bourne, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 9 1946, at 11:27 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive Heart Failure	
Due to: Cerebral vascular renal disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

Regular medical Examiner

23. SIGNATURE: [illegible] M. D. or other

Address: [illegible] Date signed: 9-9-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ Reg. Dist. No. 1010-745

1. PLACE OF DEATH:
County: Prince Georges
City or town: Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred: 4603-25th St. Mt. Rainier, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4603 - 25 - St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Elizabeth Theresa Cavanaugh

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Wh	Widowed

6.(b) Name of husband or wife: Patrick F. Cavanaugh
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 26, 1871

8. AGE: Years: 74 | Months: 9 | Days: 9 | If less than one day: hrs. min.

9. Birthplace: Moscow, Allegheny Co., Pa.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Patrick Atkinson
13. Birthplace: England

MOTHER
14. Maiden name: Mary Ann Whalen
15. Birthplace: England

16. Informant: Daughter, Mary Sloan
Address: 4603-25th St, Mt. Rainier, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 5, 1946 (month) (day) (year)
Cemetery or crematory: St. Michael's Cem.
Location: Frostburg, Md.

18. Funeral director: Wm. J. Malley
Address: 3200 Rhode Island Ave. Mt. Rainier, Md

19. Sept 5 '46 James Leary Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 4 1946, at 11:13 P.M.

21. I CERTIFY, that death occurred on the date above stated: that I attended deceased from February 1944 to Sept. 4 1946
and that I last saw h... alive on Sept. 4 1946

Immediate cause of death	DURATION
Arteriosclerotic - Hypertensive Heart disease	10 yrs. +
Due to	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Irvin B. Grassgreen M.D. M. D. or other
Address: Mt Rainier, Md Date signed: 9-4-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09186

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2010 - Fendall St. S. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3.(a) FULL NAME: JAMES M. CHUBBUCK

3.(b) Social Security Number: ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Katheryn Chubbuck
6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): August 15, 1897

8. AGE: Years	Months	Days	If less than one day
49	-	29	...hrs. ...min.

9. Birthplace: Rome, New York
(Town, county, and state)

10. Usual occupation: Decorator

11. Industry or business: Own business

FATHER
12. Name: Lynott B. Chubbuck
13. Birthplace: Binghampton, New York

MOTHER
14. Maiden name: Katheryn Chubbuck
15. Birthplace: New York

16. Informant: Decedent
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof Sept 13, 1946 (month) (day) (year)
Cemetery or crematory: St. Peter's Cemetery
Location: Rome, N.Y.

18. Funeral director: Joseph Sauls Sons Inc
Address: 1766 Penna Ave N.W., Wash DC.

19. Sept 13, 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 13 Tue 1946 at 4A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 12 Tue 1946 to Sept 13 1946
and that I last saw him alive on Sept 13 Tue 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 yrs.
Due to	
Due to	
Other conditions G. I. Tuberculosis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Bilateral pulmonary tuberculosis, ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale Md. Date signed: 9/13/46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

69187

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince George
City or town Bladensburg Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 51 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Prince George
City or town Bladensburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4116 Balt. Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME CATHERINE E. CLARK.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	Married

6.(b) Name of husband or wife Richard Clark
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 5, 1895

8. AGE: Years	Months	Days	If less than one day
51			..... hrs. ..... min.

9. Birthplace Md. (Town, county, and state)
10. Usual occupation housewife
11. Industry or business
FATHER 12. Name Henry Smith
13. Birthplace Md.
MOTHER 14. Maiden name Matilda Beckett
15. Birthplace Md.
16. Informant Gladys Daily
Address 4116 Balt. Ave.
17. Burial Date thereof Sept. 16, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Evergreen Cemetery
Location Bladensburg, Md.
18. Funeral director J. B. Johnson
Address Annapolis, Md.
19. 9/15 1946 Amanda Dawson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1946 at 4:10 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 20 1946, to Sept 13 1946
and that I last saw her alive on Sept 10 1946

Immediate cause of death	DURATION
Cardiac Infarct	2 weeks
with heart failure	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE H. W. Hudson M. D. or other
Address 509 R. I. Ave NW Date signed 9-13-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
SEP 1
1945
BUREAU

M

C

P

09188

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 231

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

1. PLACE OF DEATH
County: Pr. Geo. County
City or town: Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3½ days
Hospital, institution, or street address where death occurred: Pr. Geo. Hosp.
How long in hospital or institution? 3½ days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Pr. Geo.
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2404 Valley Way
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Diana Aileen Cobb, ~~baby girl~~

3.(b) Social Security Number

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): 9 3½ 9-3-46
8. AGE: Years 0 | Months | Days 3½ | If less than one day ... hrs. ... min.
9. Birthplace: Cheverly, Md. Pr. Geo.
(Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name: Mason Howard Cobb
13. Birthplace: —
MOTHER 14. Maiden name: Ethel Chandler
15. Birthplace: Miss
16. Informant
Address
17. Buried (Burial, cremation, or removal? Which?) Date thereof: Sept 7 1946 (month) (day) (year)
Cemetery or crematory: Evergreen
Location: Bladensburg Md
18. Funeral director: F. Gasch's Sons
Address: Hyattsville Md
19. 9/7 (Date rec'd by registrar) 1946 Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-6 — 1946, at 3 25 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-3-46 19 , to 9/5/46 19 .
and that I last saw her alive on 9/5/46 19 .
Immediate cause of death: Trauma to skull
Laceration of tentorium cerebelli
Due to: Substentorial and intra-cranial hemorrhage.
Due to: Cerebral compression
Other conditions: Pulmonary Atelectasis
(Include pregnancy within 3 months of death)
DURATION
Major findings of operations
Date of op.
Autopsy results: Same as above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?
23. SIGNATURE: Thomas A. Christensen Md
M. D. or other
Address: College Park, Md Date signed 9/6/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

09189

CERTIFICATE OF DEATH

Reg. Dist. No. 745

1. PLACE OF DEATH:
County Prince George's County
City or town Mount Rainier Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Mount Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4041 34th Street
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Claude Carolynn Colley

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Marie E Colley
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 18, 1878

8. AGE: Years 67 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual occupation Gas Salesman

11. Industry or business

FATHER
12. Name William C Colley
13. Birthplace Washington D.C.

MOTHER
14. Maiden name Claudia Dixon
15. Birthplace Virginia

16. Informant Mrs Marie E Colley
Address 4041 34th St Mt Rainier,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/21/1946. (month) (day) (year)

Cemetery or crematory Congressional
Location Washington D C.

18. Funeral director J. T. Chambers
Address 5801 Cleveland Ave, Riverdale Md.

19. Sept 20 1946 James Seery
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18, 1946, at 4:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-12 1946 to 7-18 1946
and that I last saw ..... alive on 7-17 1946

Immediate cause of death	DURATION
Carcinoma of Rectum	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE A Dietz M.D. M. D. or other
Address Hyattsville, Md. Date signed 9-19-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

09190 Reg. Dist. No. 231

1. PLACE OF DEATH:

County: P. G.

City or town: Chevy Chase (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town: 7262 Central ave. S.E. Wash. 19 (If outside city or town limits, write RURAL and give nearest town)

Street No.: (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Collins, Miss Belle

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 18 1870

8. AGE: Years: 76 | Months: 2 | Days: 14 | If less than one day: hrs. min.

D.C.

9. Birthplace: (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: John W. Collins

13. Birthplace: Wash. D.C.

MOTHER — 14. Maiden name: Mary Herfle

15. Birthplace: Md

16. Informant: Bernard B. Collins

Address: 727 Central Ave., S.E.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9-4-46 (month) (day) (year)

Cemetery or crematory: Addison Chapel

Location: Seat Pleasant, Md.

18. Funeral director: Pierce Bros.

Address: 7th & Maryland Ave. N.E.

19. 9/2 1946 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-2 1946 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 15 1945 to Sept. 2 1946 and that I last saw h[illegible] alive on September 2 1946

Immediate cause of death	DURATION
1) Intestinal Obstruction	24 hours.
Due to (a) Diabetes Mellitus	15 years
2) Cardio-Vascular-Renal	10 years
Due to (b) Pneumonia with congestion	1 week.
3) Cardiac - ?	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: William Brannin M. D. or other

Address: Capitol Hgts, Md. Date signed: 9/2/46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09191

Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Prince Georges'

City or town: Fort Washington, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Veterans Administration Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: --- County: ---

City or town: 641 F Street, S. W.
(If outside city or town limits, write RURAL and give nearest town)

Street No. Washington, D. C.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3.(a) FULL NAME: COOK, Sheridan A.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B.(b) Name of husband or wife: Mrs. Virgie Cook

B.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 6-1-1898

8. AGE: Years	Months	Days	If less than one day
48	3	18	..... hrs. ..... min.

9. Birthplace: West Virginia
(Town, county, and state)

10. Usual occupation: Painter

11. Industry or business:

FATHER
12. Name: Sherman Cook
13. Birthplace: West Virginia

MOTHER
14. Maiden name: May O. Cook
15. Birthplace: West Virginia

16. Informant: Hospital Records
Address: Fort Washington, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-23-46 (month) (day) (year)

Cemetery or crematory: Washington National Cemetery

Location: Suitland Maryland

18. Funeral director: W. E. Chambers Chambers Co.,

Address: 517 11th St, S.E., Washington, D.C.

19. Sept. 21 1946 Carrie F. Campbell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 19 1946, at 4:15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 26 1946 to Sept. 19 1946 and that I last saw him alive on September 19 1946

Immediate cause of death	DURATION
Cancer, carcinoma, of the gall bladder	6 mos.
Due to: Hepatitis, chronic	4 mos.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work? ---

23. SIGNATURE: Chas P Benson
CHAS. P. BENSON, CMO M. D. or other
Address: Ft. Washington, Md. Date signed: 9-19-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09192

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince Georges
City or town Colmar Manor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Prince Georges.
City or town Colmar Manor
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4206- Newark road.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George W. Cox

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife Mary L.
Social Security 225-10-1568 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 20th 1885

8. AGE: Years	Months	Days	If less than one day
60			..... hrs. ..... min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual occupation American Red Cross, Alex Va.
11. Industry or business
FATHER 12. Name Dandridge J. Cox
13. Birthplace Va.
MOTHER 14. Maiden name Margaret R. Nace
15. Birthplace Baltimore Md.
16. Informant Mrs Mary L. Cox.
Address 4206- Newark road Colmar Manor Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 10th 1946 (month) (day) (year)
Cemetery or crematory Mt. Olivet Cemetery
Location Washington D. C.
18. Funeral director W. H. Chambers Co.
Address Riverdale Md.
19. 9/8 1946 (Date rec'd by registrar) Amanda Dauney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7th 1946, at 5:20 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6 1945 to Sept 7 1946
and that I last saw h.. alive on Sept 7 1946

Immediate cause of death	DURATION
Cancer Stomach	
Cirrhosis Liver	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George J. Hagan M. D.
M. D. or other
Address 3717-38th Ave Date signed Sept 8-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

09193

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince Georges
City or town: Rural - Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5-6 years
Hospital, institution, or street address where death occurred: Melvin Jones Rest Home
How long in hospital or institution? 5 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: District of Columbia County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 444 - Ky. Ave. S. E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Alice V. Denton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife: Edwin Denton
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 11-1869

8. AGE: Years: 76 | Months: 9 | Days: 26 | If less than one day: hrs. min.

9. Birthplace: Pleasant Valley, Md. (Town, county, and state) Ch. Georges Co

10. Usual occupation: none

11. Industry or business:

FATHER
12. Name: Wm. Matthews
13. Birthplace: Md.

MOTHER
14. Maiden name: Martha Clubb
15. Birthplace: Md.

16. Informant: Alice M. Cook
Address: 444 - Ky. Ave. S.E. - D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/10/46 (month) (day) (year)
Cemetery or crematory: Congressional Cem.
Location: Washington D.C.

18. Funeral director: Wm. J. Bradley
Address: 3200 R.I. Ave. Mt. Rainier Md.

19. Sept 10 1946 (Date rec'd by registrar) James Beverly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 7 1946, at 8 00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 19 to September 7 1946 and that I last saw her alive on December 19

Immediate cause of death	DURATION
Chronic Hypertension	Several years
Due to: Senility	Several years
Due to: Arteriosclerosis	Several years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. Allen Griffith M. D. or other
Address: Berwyn Md. Date signed 9/8/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

09194

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince George

City or town: Bladensburg
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 4217 Edmonston Ave

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 6 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Bladensburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 4217 Edmonston Road
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: ANTON C. DUMBRIS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Sarah ann Dumbris — 6(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Dec 22 1887

8. AGE:

Years	Months	Days	If less than one day
58	27	3	____ hrs. ____ min.

9. Birthplace: Regia Lithunia
(Town, county, and state)

10. Usual occupation: instrument maker

11. Industry or business:

FATHER — 12. Name: Joseph Dumbris — 13. Birthplace: Lithunia

MOTHER — 14. Maiden name: Not Known — 15. Birthplace:

16. Informant: Mrs Sarah ann Dumbris — Address: 4217 Edmonston ave

17. (Burial, cremation, or removal. Which?) Cremation — Date thereof (month) (day) (year): Sept 26, 1946

Cemetery or crematory: Ft Lincoln

Location: Colmar Manor, Md.

18. Funeral director: N W Chambers Co

Address: 3072 M St NW

19. 9/25 19 46 (Date rec'd by registrar) — Amanda Downey (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 25 1946, at 7:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 14 1946, to Sept. 25 1946, and that I last saw h alive on Sept 21 1946.

Immediate cause of death	DURATION
Carcinoma esophagus	
Due to and cardia	7½ Mo.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: H. R. Donnelson M.D.
M. D. or other

Address: 1716 R. I. Ave. N.W. Date signed: Sept. 25-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Henry Schmidt
1716 P St. N.W.
Chestnut 34111

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

★ 09195 Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Prince Georges
City or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Few minutes
Hospital, Institution, or street address where death occurred:
Leland Memorial Hospital
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Ohio County
City or town Lima
(If outside city or town limits, write RURAL and give nearest town)
Street No. 969 South Main Street
(If rural, give LOCATION)
2.(a) If veteran, name war World War II

3.(a) FULL NAME George Farkas Jr

3.(b) Social Security Number 286-10-3467

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Unknown

6.(b) Nams of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26, 1914

8. AGE: Years 32 | Months | Days | If less than one day hrs. min.

9. Birthplace Cleveland, Ohio
(Town, county, and state)

10. Usual occupation Unknown

11. Industry or business

FATHER 12. Name George Farkas
13. Birthplace Unknown

MOTHER 14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Papers found on person of deceased

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 15, 1946 (Month) (day) (year)
Cemetery or crematory Evergreen Cemetery
Location Bladensburg, Md.

18. Funeral director J. Bassil & Son
Address Hyattsville, Md.

19. Sept 16 1946 James Leary Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6 1946 at 8 25 P M

21. I CERTIFY that death occurred on ths date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Hemorrhage and shock	
Due to Compound fracture of skull, Crushed chest	
Due to	
Other conditions Fracture of left forearm	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 9-6-46
Where did injury occur? Contee (City or town) P.G. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Route #1
Means of injury Pedestrian struck by automobile

Dept Medical Examiner

23. SIGNATURE James J. Leary M. D. or other
Address Hyattsville Md Date signed 9-14-46

MARYLAND STATE DEPARTMENT OF HEALTH

09196

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH:
County PRINCE GEORGE
City or town 8770 NEW FORT WASHINGTON
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 YEARS
Hospital, institution, or street address where death occurred: ABOVE ADDRESS
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Pr. George
City or town Fort Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8770 new fort Washington Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Harry Jackson Gamble

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) april 23, 1906

8. AGE: Years	Months	Days	If less than one day
40	4	17	..... hrs. ..... min.

9. Birthplace Pa. (Town, county, and state)
10. Usual occupation always an Invalid
11. Industry or business

FATHER
12. Name Alvey Denton Gamble
13. Birthplace Pa.

MOTHER
14. Maiden name Emma Wirie
15. Birthplace Pa.

16. Informant David F. Green
Address 8770 New Ft. Rd. Washington 20 D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/11/46 (month) (day) (year)
Cemetery or crematory Mt. Rest
Location La Plata, Md.

18. Funeral director Hunt & Ryon
Address Waldorf, Md.

19. Sept 10 1946 M. C. McNeal Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9 1946, at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from AUGUST 18 1946 to SEPT. 8 1946 and that I last saw h IM alive on SEPT. 8 1946

Immediate cause of death	DURATION
CORONARY THROMBOSIS	22 DAYS
Due to CORONARY ARTERIO SCLEROSIS	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Arnold Sobel, M.D.
M. D. or other
Address FORT WASHINGTON, MD. Date signed 9/10/46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

09197

CERTIFICATE OF DEATH

★ Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cheverly (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Prince Georges General Hospital
How long in hospital or institution? 6 hours

2. USUAL RESIDENCE (HOME) OF DECEASED
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Cheverly (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Garner, M. Thomas

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 19 1878

8. AGE: Years 68 | Months 9 | Days | If less than one day hrs. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: James Garner
13. Birthplace: Maryland

MOTHER
14. Maiden name: Missouri Hawkins
15. Birthplace: Maryland

16. Informant: William A Garner (son)
Address: Croome Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9 20 46 (month) (day) (year)
Cemetery or crematory: St Thomas
Location: Croom Md

18. Funeral director: Ritchie Bros
Address: Upper Marlboro Md

19. 9/18/1946 (Date rec'd by registrar) Amanda Deaner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 18 1946, at 8:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1945 to Sept. 18 1946 and that I last saw him alive on September 18 1946

	DURATION
Immediate cause of death: Congestive Heart Failure	1 week
Due to: Hypertension -	10 yrs
Due to: Nephritis	5 yrs.
Other conditions: Arteriosclerosis	20 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: James E. Garner M. D. or other
Address: Upper Marlboro, Md. Date signed: 9-18-46

09198

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 hrs - 15 min
Hospital, institution, or street address where death occurred:
Prince Georges General Hospital
How long in hospital or institution? 7 hrs - 15 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Fort Pleasant
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6906 - Delwood Ave.
(If rural, give LOCATION) Fort Pleasant, Md.
2.(a) If veteran, name war:

3.(a) FULL NAME: Gibbs, Mr. Rollin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	married

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1888

8. AGE:	Years	Months	Days	If less than one day
58	58			hrs. min.

9. Birthplace: Omaha, Nebraska (Town, county, and state)
10. Usual occupation: U. S. Treasury Dept.
11. Industry or business:
FATHER 12. Name: Isaac Gibbs
13. Birthplace: Nebraska
MOTHER 14. Maiden name: Evelyn M. Gibbs
15. Birthplace: Nebraska
16. Informant: Mrs. Clifford C. Hamilton
Address: 6904 Delwood Ave., Fort Pleasant
17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept 12, 1946 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D.C.
18. Funeral director: Martin W. Hyson Co.
Address: 1300 "N" St. N.W. Washington, D.C.
19. 9/12 1946 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 12, 1946, at 4:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1946, to Sept 12 1946
and that I last saw him alive on Sept 12 1946.

Immediate cause of death	DURATION
Cerebral thrombosis	5 years
Heart disease	
Congestive failure	3 days
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: William Brainin M. D. coroner
Address: Capitol Heights, Md. Date signed: 9/12/46

Evidence for change of birth date of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

FILM No. I 07 OCT 8 1946

CERTIFICATE OF DEATH

09193

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Chevorley (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death: Died in transit to hospital
Hospital, Institution, or street address where death occurred: Emergency entrance, Chevorley Md
How long in hospital or institution? not admitted

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Colmar Manor (If outside city or town limits, write RURAL and give nearest town)
Street No. 4015 Laurence St. (If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Mrs anna Gillette

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Seymour Gillette

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): ~~Oct 5~~ March 28 1868

8. AGE: Years	Months	Days	If less than one day
~~78~~ 78	4	21	..... hrs. ..... min.

9. Birthplace: Naples New York U.S.A. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: ~~Lum~~ Wright
13. Birthplace: Naples New York

MOTHER
14. Maiden name: Mary Bartholemew
15. Birthplace: Naples NY

16. Informant: Mrs. Glen M Gillette
Address: 4015 Laurence St Colmar Manor Md

17. Burial, cremation, or removal, Which?: Burial Date thereof: Sept 21, 1946 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Washington D.C.

18. Funeral director: F Escoba Sons
Address: Hyattsville Md.

19. 9/20/1946 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-19- 1946 at 12 45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-19 1946 to 9-19 1946 and that I last saw h.e.r alive on 9-19-46 1946

Immediate cause of death	DURATION
(Pulmonary Edema)	
Due to: Arterio Sclerotic Heart disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Clayton O Watkins MD M. D. or other
Address: 5308 Annapolis Rd Bladensburg Md Date signed: 9-19-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-D)

CERTIFICATE OF DEATH

09209 Reg. Dist. No. 345

1. PLACE OF DEATH:
County: Prince George
City or town: Riverdale Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 ~~5~~ months 13 days
Hospital, institution, or street address where death occurred:
Leland Memorial Hospital
How long in hospital or institution? 4 mos. 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Belmont
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5015 Indian Lane
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Emma Hunter Goodwin

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Joseph A. Goodwin
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 24, 1858

8. AGE:

Years	Months	Days	If less than one day
87	11	12	..... hrs. ..... min.

9. Birthplace: Wake County N.C.
(Town, county, and state)
10. Usual occupation: Maid
11. Industry or business:
FATHER 12. Name: James Everett Utley
13. Birthplace: N.C.
MOTHER 14. Maiden name: Martha Hunter
15. Birthplace: N.C.
16. Informant: Mrs. Ruby Goodwin Parker
Address: 40 Prospect Pkwy Portsmouth, Va.
17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept 6 1946 (month) (day) (year)
Cemetery or crematory:
Location: 1756 Pa ave N W
18. Funeral director: Joseph Gawler's Sons
Address: 1756 Penna Ave N.W
Waiting for D. Clerey
19. Sept 6 1946 James Clerey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 6, 1946, at 10 17 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 23, 1946, to Sept. 6, 1946
and that I last saw h... alive on Sept 5, 1946

Immediate cause of death	DURATION
Heart disease	5 yrs.
Due to: Generalized Arteriosclerosis	2.5 yrs
Due to:	
Other conditions: Secondary nutritional anemia	1 yr

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

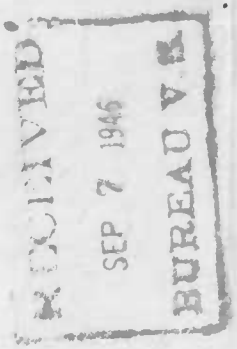
23. SIGNATURE: Walcott W. Gibson, M.D.
M. D. or other
Address: Date signed:

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

4309
Harrag at St
Ky.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

09201

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Prince Georges

City or town: Cedar Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, Institution, or street address where death occurred:

1108 - 64th Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Cedar Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1108 - 64th Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Howard Edward Green

3.(b) Social Security Number: 578-09-2284

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Mary Louise Green

6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): June 7, 1901

8. AGE: Years: 45 Months: 2 Days: 26 If less than one day: hrs. min.

9. Birthplace: Leaftown, Md. (Town, county, and state)

10. Usual occupation: Chicken picker

11. Industry or business

FATHER

12. Name: Arthur Green

13. Birthplace: Maryland

MOTHER

14. Maiden name: Emma Minchin

15. Birthplace: Maryland

16. Informant: Mary Louise Green

Address: 1108 - 64th Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 6 1946 (month) (day) (year)

Cemetery or crematory: Payne Cem.

Location: Washington, D.C.

16. Funeral director: J. B. Johnson

Address: Annapolis, Md.

19. Sept. 5 1946 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 2 1946, at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Congestive heart failure	
Due to Myocarditis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Deputy Medical Examiner

M. D. or other

Address: Forestville, Md. Date signed: 9-2-46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09202

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince Georges
City or town: Chenerly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred:
Pr. Georges Hosp.
How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Pr. Geo.
City or town: Mt. Ranier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4700 34th St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Gunion, Mrs. Jessie

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Edward Ellsworth Gunion
6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): June 19, 1902

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
44				

9. Birthplace: Mass
(Town, county, and state)
10. Usual occupation: Manager
11. Industry or business: Stones merchants Exp
12. FATHER Name: John P. MacIntosh
13. Birthplace: Scotland
14. MOTHER Maiden name: Jessie Sims
15. Birthplace: Scotland
16. Informant: Ellsworth Gunion
Address: 4700 34th St. Mt. Ranier Md.
17. Burial (Burial, cremation, or removal, Which?) Date thereof: Sept 4-46 (month) (day) (year)
Cemetery or crematory: Ft. Lincoln Cem.
Location: Wash D.C.
18. Funeral director: Wm Chambers Co
Address: Riverdale - Md
19. 9/3 1946 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-1-46 19—, at 5:05 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Dopamine	
Due to: Barbiturate Poisoning	
Due to:	
Other conditions: Hypostatic pneumonia, both lungs	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of: 8-29-46
Where did injury occur? Mt Ranier (City or town) P.G. (County) Md (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: Took barbiturates Injured at work? No

23. SIGNATURE: Deputy Medical Examiner
M. D. or other
Address: Forestville Md Date signed: 9-2-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-2)

CERTIFICATE OF DEATH

09203

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 minutes

Hospital, institution, or street address where death occurred: Leland Memorial Hosp

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: California County: Los Angeles

City or town: Long Beach (If outside city or town limits, write RURAL and give nearest town)

Street No. 314 Market Street (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Marie Helen Halby

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 17, 1919

8. AGE: Years: 27 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Buffalo N. Y. (Town, county, and state)

10. Usual occupation: Ambulance Driver

11. Industry or business: U. S. Army

FATHER — 12. Name: George Hoelzl

FATHER — 13. Birthplace: Buffalo N.Y.

MOTHER — 14. Maiden name: Helen Wagner

MOTHER — 15. Birthplace: Buffalo, N.Y.

16. Informant: Mrs. M. Halby

Address: 314 Market St, Long Beach Calif.

17. (Burial, cremation, or removal. Which?) Transportation

Date thereof: Sept 25, 1946 (month) (day) (year)

Cemetery or crematory: Long Beach California

Location: California

19. Funeral director: F. Eastes Sons

Address: Hyattsville Md.

19. Sept 25 1946 (Date rec'd by registrar)

Mrs. Jas. Severe Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 23 19 46, at 4:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage	
Shock	
Due to: Compound fracture	
of skull	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 9-23-46

Where did injury occur? Oak Crest (City or town) Los Angeles (County) (State)

Injured at home, farm, industry, public place (where?) Route #1

Means of injury: Pedestrian struck by Injured at work? No

Hospital medical Examiner

23. SIGNATURE: [signature] M. D. or other

Address: Freehold N.J. Date signed 9-23-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09204

CERTIFICATE OF DEATH

Reg. Diat. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo., 15 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 mo., 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1211 N. Capital Street
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: HARMON EUGENE P.

3. (b) Social Security Number: 239-03-9571

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Virginia Harmon
6.(c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): November 11, 1905

8. AGE:

Years	Months	Days	If less than one day
40	10	7	..... hrs. ..... min.

9. Birthplace: Greenville, Tennessee
(Town, county, and state)

10. Usual occupation: Supervisor of Fleet of Trucks

11. Industry or business:

FATHER
12. Name: Robert T. Harmon
13. Birthplace: Greenville, Tennessee

MOTHER
14. Maiden name: Pauline Chandley
15. Birthplace: North Carolina

16. Informant: Decedent
Address:

17. (Burial, cremation, or removal. Which?) Removal — Date thereof: 9 - 18 - 46 (month) (day) (year)
Cemetery or crematory: To Wash. D.C.
Location:

18. Funeral director: T. F. Costello
Address: 1722 - N. Cap. St. Wash. D.C.

19. (Date rec'd by registrar) Sept 18, 1946 — Rowland S. Phillips, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 18, 1946, at 2:50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/3, 1946, to 9/18, 1946, and that I last saw h... alive on 9/18, 1946.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	20 mos.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.: .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of: .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): .....
Means of injury: ..... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. (M. D. or other)
Address: Glenn Dale, Md. Date signed: 9/18/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15-a)

CERTIFICATE OF DEATH

09205 Reg. Dist. No. 239

1. PLACE OF DEATH:
County Prince George's
City or town Laurel —
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Brookfield md RFD
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME JAMES ERNEST HAWKINS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14 - 1945

8. AGE: Years 1 | Months 5 | Days 10 | If less than one day ... hrs. ... min.

9. Birthplace Fredricksburg Va
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Joseph Claggett Hawkins
13. Birthplace md

MOTHER 14. Maiden name Margaret Griffin
15. Birthplace Gaithersburg Md

16. Informant Joseph C Hawkins
Address Gaithersburg md

17. Cremation (Burial, cremation, or removal—Which?) Date thereof Sept 24 1946 (month) (day) (year)
Cemetery or crematory Fort Lincoln
Location D C

18. Funeral director Robt W Barber
Address Lanham md

19. April 24 1946 M. Brashears
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24 1946, at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 24 19.. to Sept. 24 1946
and that I last saw him alive on Sept 24 1946 19..

Immediate cause of death	DURATION
Acute Cardiac Dilitation	1 d
Due to Hydrocephalus	April 4 45
Due to Interstitial Pulmonal Interdilatitis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE B Ware M. D. or other
Address Date signed

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince Georges

City or town: Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Prince Georges County Hospital, Chevrly, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infante give residence of mother)

State: Maryland County: Prince Georges

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ———

3.(a) FULL NAME: ROBERT G. HENRY

3.(b) Social Security Number: ———

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

8.(b) Name of husband or wife: unknown

8.(c) If alive, give age: Decd. years

7. Birth date of deceased (mo., day, yr.): 1867

8. AGE: Years	Months	Days	If less than one day
79			....hrs. ....min.

9. Birthplace: Charlotte County, Virginia (Town, county, and state)

10. Usual occupation: Retired - Commission Merchant

11. Industry or business

FATHER — 12. Name: Dr. Stanhope Henry

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Mary Gaines

15. Birthplace: Virginia

16. Informant: Mr. Wugene H. McLachlen

Address: McLachlen Building, Washington, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 30, 1946 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Cemetery

Location: 3201-Bladensburg Rd., Prince Geo. County

18. Funeral director: Martin W. Hysong Co. Md.

Address: 1300 - N St. N.W., Washington, D.C.

19. 9/27/46 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-27 1946 at 09 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-10 1946 to 9-27 1946 and that I last saw him alive on 9-26 1946

Immediate cause of death	DURATION
Pernicious Anemia	2 yrs
Due to	
Due to	
Other conditions: Malnutrition	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jesse and Hays M. D. or other

Address: Hyattsville, Md. Date signed: 9-27-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

C9207

Reg. Dist. No. 239

FILM No. 107 SEP 16 1946

1. PLACE OF DEATH:
County: Prince George
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
Laurel Sanitarium
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William Francis Higgins

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary A. Mugent
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 22 - 1899

8. AGE: Years	Months	Days	If less than one day
46 45	11	17	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Heating contractor
11. Industry or business
MOTHER 12. Name: Lawrence P. Higgins
13. Birthplace: Washington, D.C.
FATHER 14. Maiden name: Helen Tracy
15. Birthplace: Washington, D. C.
16. Informant: Sanitarium Records
Address: Laurel San., Laurel, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/11/46 (month) (day) (year)
Cemetery or crematory: St. Rose Cemetery
Location: Clopper Rd.
18. Funeral director: Ernest L. Gaither
Address: Gaithersburg, Md.
19. Sept 9 1946 M. Blackwell Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 5 1946, at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 5 1946 to September 8 1946
and that I last saw him alive on September 5 1946

Immediate cause of death	DURATION
Acute Toxic Myocarditis	Sudden
Due to: Alcoholism - acute	Week
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John L. Weltner M.D.
M. D. or other
Address: Laurel Sanitarium, Laurel, Maryland Date signed:

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

C9208

Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Prince Georges

City or town: Fort Washington
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 52 days

Hospital, Institution, or street address where death occurred:
Veterans Administration Hospital

How long in hospital or institution? 52 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Gambrills
(If outside city or town limits, write RURAL and give nearest town)

Street No. ____
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME: HOWARD, William P.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ida M. Howard

6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): December 13, 1895

8. AGE: Years	Months	Days	If less than one day
50	8	26	____ hrs. ____ min.

9. Birthplace: Wellsville, Anne Arundel Co., Md.
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER
12. Name: William Howard
13. Birthplace: Alabama

MOTHER
14. Maiden name: Rachel A. Robenson
15. Birthplace: Calvert Co., Maryland

16. Informant: Hospital Records

Address: Fort Washington, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 9 1946 (month) (day) (year)

Cemetery or crematory: Church of God Cemetery

Location: Gambrills, Maryland

18. Funeral director: W. W. Chambers

Address: 517 11th St., S.E., Washington, D.C.

19. 9-9-46 (Date rec'd by registrar) Thos. O Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 9 1946, at 2:44A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18 1946, to September 9 1946 and that I last saw him alive on September 9 1946

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to Hypertension and coronary arteriosclerosis, cardiac enlarge-	
Due to ment., myocardial insufficiency, anginal syndrome, Class V	
Other conditions Hemiplegia, right	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. ____

Autopsy results: Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work? ____

23. SIGNATURE: Charles P Benson M.D.
CHARLES P. BENSON, M. D. M. D. or other

Address: VA Hosp., Ft. Washington, Md. Date Signed: 9/9/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

C9209

CERTIFICATE OF DEATH

Reg. Diat. No. 231

1. PLACE OF DEATH:

County Prince Georges ~~Concoat Hospital~~

City or town - Cheverly md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 hrs - 50 min

Hospital, Institution, or street address where death occurred:

Prince Georges General Hospital

How long in hospital or institution? 24 hrs. - 50 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Prince Georges

City or town Mt Ranier

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4572 - 32nd St Mt Ranier

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles Howlin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

8.(b) Name of husband or wife Emma B. Howlin

8.(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) May 25, 1885

8. AGE:

Years	Months	Days	If less than one day
61	3	19	....hrs. ....min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual occupation Retired

11. Industry or business Penna. Rail Road.

FATHER 12. Name Charles Howlin

13. Birthplace D.C.

MOTHER 14. Maiden name Alta S. Berkley

15. Birthplace D.C.

16. Informant Charles Howlin, Jr

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 17 1946 (month) (day) (year)

Cemetery or crematory Ft. Lincoln

Location Cottage City Md.

18. Funeral director J. Daniels & Sons

Address Hyattsville, Md.

19. Sept 15 1946 (Date rec'd by registrar) Amanda Donovan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14, 1946, at 12 35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-3 1946, to 9-14 1946

and that I last saw h alive on 9-14 1946

	DURATION
Immediate cause of death Coronary Occlusion	24 hours
Due to Hypertensive Arteriosclerotic Heart Disease	4 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ....Date of op.....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. B. Burgess M.D. M. D. or other

Address Mt. Rainier Md. Date signed 9-15-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

69210

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince Georges

City or town: Chevrly (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 hours

Hospital, Institution, or street address where death occurred: Prince Georges General Hospital

How long in hospital or institution? 3 hours

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Prince George

City or town: Cottage City (If outside city or town limits, write RURAL and give nearest town)

Street No. 3726 - 40th Aves, (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Baby Girl Hudgins

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	w	

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept-4, 1946

8. AGE:

Years	Months	Days	If less than one day
0	0	0	3 hrs. min.

9. Birthplace: Cheverly, Prince Geo: Maryland (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Edward Hudgins

13. Birthplace: Roanoke, Virginia

MOTHER — 14. Maiden name: Leona Valpeet

15. Birthplace: Maryland

16. Informant: Leona V. Hudgins

Address: 3726 40th Ave Cottage City, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: 9/5/46 (month) (day) (year)

Cemetery or crematory: Prince George's General Hospital

Location: Cheverly, Md.

18. Funeral director: A. R. Besley, Superintendent

Address: same

19. 9/16 1946 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-4 1946 at 10 a/p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 4 - 1946 to Sept 4 - 1946 and that I last saw her alive on Sept 4 1946

Immediate cause of death	DURATION
Premature	Few hours
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: M. D. or other

Address: Date signed: 9/17/46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (930)

CERTIFICATE OF DEATH

C9211

Reg. Dist. No. 172

1. PLACE OF DEATH:

County: Pr. Georges

City or town: Ritchie Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Weeks

Hospital, Institution, or street address where death occurred:
6808 White house Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Calvert

City or town: Dowell Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Richard Edward Humphreys

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband/wife: Lilly M. Humphreys

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 9 1870

8. AGE: Years: 76 Months: Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Cove Point Calvert Co, Md.
(Town, county, and state)

10. Usual occupation: Insurance Agent

11. Industry or business:

FATHER
12. Name: Richard Humphreys
13. Birthplace: Cove Point Calvert Co Md

MOTHER
14. Maiden name: Mary Day
15. Birthplace: Unknown

16. Informant: John Edgar Humphreys
Address: 1120 Monroe St Eastport Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 11, 1946 (month) (day) (year)

Cemetery or crematory: St. Pauls

Location: Lusby, Md

18. Funeral director: A. A. Parkinson & Son

Address: Mutual, Md

19. Sept. 8 1946 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 8 1946, at 7:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 27 1946, to Sept 8 1946 and that I last saw h.i.m. alive on Sept 7 1946

	DURATION
Immediate cause of death: Cerebral Hemorrhage	11 days
Due to: General arteriosclerosis	4 Yrs (History)
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. Swit Ritchie M.D.
M. D. or other

Address: 6906 Ritchie Rd SE Date signed: Sept 8 1946
Wash 19, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18-6

09212

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale - RURAL
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 749- Morton St., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: -

3.(a) FULL NAME: JEAN L. JOHNSON

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	Col	Married

6.(b) Name of husband or wife: Arnold Johnson

6.(c) If alive, give age: 24 years

7. Birth date of deceased (mo., day, yr.): Jan. 19, 1924

8. AGE: Years	Months	Days	If less than one day
22	8	2	...hrs. ...min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: Printer's assistant (Bu. of Printing and Engraving)

11. Industry or business:

FATHER
12. Name: John Wormsley
13. Birthplace: ?, Virginia

MOTHER
14. Maiden name: Ruth Cook
15. Birthplace: Wash., D. C.

16. Informant: deceased

Address

17. (Burial, cremation, or removal? Which?) Removal Date thereof: 9-22-46 (month) (day) (year)

Cemetery or crematory:

Location: to Washington, D.C.

18. Funeral director: W. Ernest Garrett Co.

Address: 1432 Fenn St. N.W. Wash. D.C.

19. Sept. 24, 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 21, 1946, at 4:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/30/46, 1946, to 9/21/46, 1946, and that I last saw h[illegible] alive on 9/21/46, 1946.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	5 Mo's.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 9/21/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

09213

CERTIFICATE OF DEATH

Reg. Diat. No. 245

1. PLACE OF DEATH:
County Prince George's
City or town North Brentwood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 2 years
Hospital, Institution, or street address where death occurred:
4525-37th Place
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town North Brentwood
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4528-39th Place
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME John Henry Johnson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	married

6.(b) Name of husband or wife Mabel E. Johnson
6.(c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) Oct 26, 1901

8. AGE: Years 44 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business

FATHER 12. Name John Henry Johnson
13. Birthplace Maryland

MOTHER 14. Maiden name Kennetta Fowler
15. Birthplace Maryland

16. Informant Edgar F. Johnson
Address 4503 40th Ave, North Brentwood

17. Removal (Burial, cremation, or removal. Which?) Date thereof Sept 7 1946 (month) (day) (year)

Cemetery or crematory Bradley Lawn Park
Location
18. Funeral director W. Ernest Jarvis Co.
Address 1432 Kearny Ave. Kearny N. J.

19. Sept 7 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1946 at 6 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Congestive heart failure	
Due to Cardiovascular renal disease	
Due to	
Other conditions Emphysema & Diabetes	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury Injured at work?

23. SIGNATURE Deputy medical examiner James D. Bond (M. D. or other)
Address Forestville Md. Date signed 9-7-46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

09214

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Berwyn Heights, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? —

Hospital, Institution, or street address where death occurred: —

How long in hospital or Institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Berwyn Heights, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 8814 - Edmonston Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Wilmer Peirce Johnston

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna K. Johnston

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): October 10, 1881

8. AGE: Years: 64 | Months: 11 | Days: 8 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Rectorstown, Virginia
(Town, county, and state)

10. Usual occupation: Clergyman

11. Industry or business:

FATHER
12. Name: Wandley P. Johnston
13. Birthplace: Virginia

MOTHER
14. Maiden name: Annie Elisabeth Davis
15. Birthplace: Virginia

16. Informant: Mrs. Anna K. Johnston
Address: 8814 - Edmonston Ave. Berwyn Hgts. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 21, 1946 (month) (day) (year)

Cemetery or crematory: Uffenville,

Location: Uffenville, Virginia

16. Funeral director: Martin W. Hyson Co.

Address: 1300 - N St. N.W., Wash. D.C.

Sept 18 1946 James Seay
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/18 1946 at 1200 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9 1941 to Sept 18 1946 and that I last saw h... alive on 9/18 1946

Immediate cause of death: Coronary Thrombosis — DURATION: 5 minutes

Due to: arteriosclerosis — 10 yrs

Due to: Hypertension — 10 yrs

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. ____

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Thomas A. Christensen Jr. M.D.
M. D. or other

Address: College Park, Md. Date signed: 9/18/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND

COPY OF CERTIFICATE OF DEATH

(NOTE—This is not a legal document)

STATE DEPARTMENT OF HEALTH
Bureau of Vital Statistics
Registration Dist. No. 2-30245

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County PRINCE GEORGES
City or town BERWYN HEIGHTS Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County PRINCE GEORGES
City or town BERWYN HTS MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8814 - EDMONSTON AVENUE
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME WILMER PIERCE JOHNSTON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife ANNA K. JOHNSTON
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) OCTOBER 10 1881

8. AGE: Years	Months	Days	If less than one day
64	11	8	..... hrs. ..... min.

9. Birthplace RECTORSTOWN VIRGINIA
(Town, county, and state)
10. Usual occupation CLERGYMAN
11. Industry or business

FATHER
12. Name MANDLEY P JOHNSTON
13. Birthplace VIRGINIA

MOTHER
14. Maiden name ANNIE ELIZABETH DAVIS
15. Birthplace VIRGINIA

16. Informant MRS ANNA K. JOHNSTON
Address 8814 Edmonston Ave BERWYN HTS

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof SEPT 21-1946 (month) (day) (year)
Cemetery or crematory UPPERVILLE
Location UPPERVILLE VIRGINIA

18. Funeral director MARTIN W HYSONG Co
Address 1300 - N ST NW WASHINGTON DC

19. SEPT-18-1946 (Date rec'd by registrar) JAMES SEVERE Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 18 1946, at 12 10 AM.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from JULY 9th 1941 to SEPT 18 1946 and that I last saw h. INV. alive on SEPTEMBER 18 1946

Immediate cause of death	DURATION
CORONARY THROMBOSIS	5 MINUTES
Due to ARTERIOSCLEROSIS	10 YEARS
Due to HYPERTENSION	10 YEARS
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE THOMAS A CHRISTENSEN MD M. D. or other
Address COLLEGE PARK MD Date signed 9-18-46

24. CERTIFIED AS CORRECT TO COUNTY REGISTRAR BY JOHN D. SMITH Local Registrar

S. A16
Plate 6/40

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1103

CERTIFICATE OF DEATH

★09215

Reg. Dist. No. 725

1. PLACE OF DEATH:

County Prince Georges

City or town Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 hr 50 minutes

Hospital, institution, or street address where death occurred:

Leland Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Jones

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1891

8. AGE: Years 55 Months Days If less than one day hrs. min.

9. Birthplace Philadelphia, Pa (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name unknown

13. Birthplace unknown

MOTHER 14. Maiden name unknown

15. Birthplace unknown

16. Informant Police Records

Address Hyattsville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 15, 1946 (month) (day) (year)

Cemetery or crematory Evergreen Cemetery

Location Bladensburg Maryland

18. Funeral director L. Gustin Sons

Address Hyattsville Md.

19. Sept 16 1946 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1946, at 10:50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Hemorrhage and shock	
Due to Compound fracture of skull	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 9-14-46

Where did injury occur? Cartie (City or town) PG (County) Md (State)

Injured at home, farm, industry, public place (where?) Route #1

Means of injury Pedestrian struck by Injured at work?

Deputy medical Examiner

23. SIGNATURE James Seery M. D. or other

Address Hyattsville md Date signed 9-14-46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09216

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

Reg. Diat. No. 242.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Prince Georges County
City or town: Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 81 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pro Geo Co
City or town: Lanham Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Bowie-Glendale Read
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John Henry Kagle

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Gertrude Kagle
6.(c) If alive, give age: 72 yrs. years

7. Birth date of deceased (mo., day, yr.): April 13, 1865

8. AGE: Years	Months	Days	If less than one day
81			....hrs. ....min.

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: James Kagle
13. Birthplace: England

MOTHER
14. Maiden name: Ellen Davison
15. Birthplace: England

16. Informant: Gertrude Kagle
Address: Lanham Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 10, 1946 (month) (day) (year)
Cemetery or crematory: Whitfield Cemetery
Location: Lanham Maryland

18. Funeral director: F. Gasch's Sons
Address: Hyattsville Maryland

19. Sept 9th 1946. (Date rec'd by registrar) Mrs Jack Bennette Dep. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 8. 1946, at 9 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1946, to Sept 8 1946
and that I last saw h.. alive on Sept 8 1946

Immediate cause of death	DURATION
Cerebral haemorrhage	5 wk
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert S. McCarney M.D. M. D. or other
Address: 40 Main St Laurel Md. Date signed: 9/9/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09217

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Pro Geo Co
City or town: Vista Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pro Geo Co
City or town: Bladensburg Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4410 46th street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Bertha Kennedy

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	seperated

6.(b) Name of husband or wife: Ernest Kennedy
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 6, 1915

8. AGE: Years	Months	Days	If less than one day
31	5	22	hrs. min.

9. Birthplace: North carolina (Town, county, and state)
10. Usual occupation: General housework
11. Industry or business

FATHER
12. Name: Lee Jackson
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Liza Thomas
15. Birthplace: North Carolina

16. Informant: Lula Jackson
Address: Capital View Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept 29, 1946 (month) (day) (year)
Cemetery or crematory: Jarvis Funeral Home
Location: 1432 U st N W Washington D. C.

18. Funeral director: F. Gasch's Sons
Address: Hyattsville Maryland.

19. Sept 29 19 46 (Date) Rec'd by registrar October 2 46 Amanda Mooney Registrar
Mel Jack Bunting

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 28 1946, at 9 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19, to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to Gun shot wound in chest	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: homicide Date of: 9-28-46
Where did injury occur? Vista (City or town) P. G. (County) Md (State)
Injured at home, farm, industry, public place (where?): Lane Hall
Means of injury: Shot in chest Injured at work? no

23. SIGNATURE: James J. Booth M. D. or other
Address: Forestville md Date signed: 9-28-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09218

FILM No. I 07 OCT 8 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? ...
Hospital, institution, or street address where death occurred: Prince Georges General Hospital
How long in hospital or institution? ...

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prince George.
City or town: Cheverly Nyatsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4501 - Kennedy St.
(If rural, give LOCATION)
2.(a) If veteran, name war ...

3. (a) FULL NAME Robert A. King

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	widowed

6.(b) Name of husband or wife ...
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1870

8. AGE: Years 76 | Months 9 mo | Days 29 | If less than one day ... hrs. ... min.

9. Birthplace Wash. D. C. (Town, county, and state)

10. Usual occupation Retired

11. Industry or business U.S. govt

FATHER 12. Name King, Mc John I

13. Birthplace Wash. D. C.

MOTHER 14. Maiden name Oliver, Miss Marie

15. Birthplace D C

16. Informant Mr. Robert King

Address 4501 Kennedy St. Nyatsville

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 23, 1946. (Mo.) (Day) (Year)

Cemetery or crematory Rock Creek

Location Washington D.C.

18. Funeral director F. Gracie Sons

Address Nyatsville Md.

19. 9/20 1946 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/19/46, at 8:27 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 1945, to Sept 19 1946

and that I last saw h... alive on Sept 16 1946

Immediate cause of death	DURATION
Cerebral Accident.	
Due to Hypertensive Heart disease	
Due to ...	
Other conditions ...	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE Clark Wolf. M. D. or other

Address Hyattsville Md. Date signed 9/20/46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

09219

Reg. Dist. No. 239

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Laurel

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 months

Hospital, Institution, or street address where death occurred: 332 Montgomery St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Laurel Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 332 Montgomery St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Viola Mary Hawley

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Mrs Franklin Hawley

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 21, 1877

8. AGE:

Years	Months	Days	If less than one day
69	6	0	hrs. min.

9. Birthplace: Clark County Virginia

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER

12. Name: Archibald Fletcher

13. Birthplace: Clark County Virginia

MOTHER

14. Maiden name: Emma Frances Shepherd

15. Birthplace: Clark County Virginia

16. Informant: Mrs Frances Shifflett (daughter)

Address: 332 Montgomery St, Laurel Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 24 1946 (month) (day) (year)

Cemetery or crematory: Savage Cemetery

Location: Savage Md

18. Funeral director: Ridgely Selby

Address: 401 Washington Laurel Md

19. 9-24 1946 (Date rec'd by registrar) Cora E. Wachter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 21 1946 at 11:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5 1944 to Sept 21 1946

and that I last saw h[illegible]ive on Sept 21 1946

Immediate cause of death	DURATION
Cerebral haemorrhage	15 mo
Due to: Hypertention	10 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert L McGreevy M.D. M. D. or other

Address: 402 Main St Laurel Md Date signed: 9/27/46

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 22

CERTIFICATE OF DEATH

09220

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Georges
City or town: Bladensburg, Md. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: MD County: PR. GEO
City or town: BLADENSBURG (If outside city or town limits, write RURAL and give nearest town)
Street No. 4102 - 48th ST. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lena Lee

3.(b) Social Security Number

4. Sex: FE
5. Color or race: Col
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): AUG. 17, 1876
8. AGE: Years 70 | Months | Days | If less than one day ... hrs. ... min.
9. Birthplace: RIVERDALE, MD. (Town, county, and state)
10. Usual occupation: DOMESTIC
11. Industry or business

FATHER
12. Name: ALEXANDER SCOTT
13. Birthplace: MD

MOTHER
14. Maiden name: JENNY SCOTT
15. Birthplace: MD

16. Informant: CALVERT LEE
Address: 4102-48th STREET

17. Removal Date thereof: Sept 26, 1946 (Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory
Location: Washington, DC.

18. Funeral director: John T. Stewart
Address: 30 H St NE

19. Sept. 26 1946 (Date rec'd by registrar) Carrie Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 26, 1946, at 9:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946, to Sept 26 1946 and that I last saw her alive on Sept 24 1946

Immediate cause of death: Chronic Valvular Heart Disease — DURATION: 2-4 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Edwin L. Williams M. D. or other
Address: 4629 Deane Ave NE Date signed: 9-26-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (64)

CERTIFICATE OF DEATH

09221

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince Georges
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15½ hours
Hospital, institution, or street address where death occurred:
Leland Memorial Hospital
How long in hospital or institution? 15½ hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County: Arlington
City or town: Arlington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: N. Monroe St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JAMES EDWARD LEWIS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Iris Lewis
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): October 5, 1918

8. AGE: Years	Months	Days	If less than one day
27	11	24	____ hrs. ____ min.

9. Birthplace: Clinton, Maryland (Town, county, and state)
10. Usual occupation: Counterman
11. Industry or business:

FATHER
12. Name: Elick D. Lewis
13. Birthplace: St. Mary's Co., Md.

MOTHER
14. Maiden name: Emma Lee Gough
15. Birthplace: Leesburg, Virginia

16. Informant: Mrs. Lena Lewis
Address: 5807 40th Ave., Hyattsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 2. 1946. (month) (day) (year)
Cemetery or crematory: Evergreen Cemetery
Location: Bladensburg Md

18. Funeral director: F Gaschi Sons
Address: Hyattsville Md

19. Oct. 2" 1946 (Date rec'd by registrar) Mrs. Jas. Devese Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 29 1946, at 7¼ P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____
and that I last saw h____ alive on ____ 19____

Immediate cause of death	DURATION
Hemorrhage and Shock	
Due to Gun shot Wound	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Suicide Date of 9-28-46
Where did injury occur? Mt. Rainier P.G. Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury: Shot with rifle, injured at work? no

Deputy medical Examiner
23. SIGNATURE: [illegible] M. D. or other
Address: Westville Md Date signed 9-29-46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09222

CERTIFICATE OF DEATH

Reg. Diat. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Md. - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 15 days
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 3 months, 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 503- 8'th St., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: -

3.(a) FULL NAME: You D. Lock

3.(b) Social Security Number: 577-34-8833

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Chinese	single

6.(b) Name of husband or wife: -
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 15, 1901

8. AGE:

Years	Months	Days	If less than one day
45	8	4	..... hrs. ..... min.

9. Birthplace: San Francisco, Calif.
(Town, county, and state)
10. Usual occupation: laundryman
11. Industry or business: -

FATHER
12. Name: Tai Ha Lock
13. Birthplace: China

MOTHER
14. Maiden name: Chin Kin
15. Birthplace: China

16. Informant: deceased
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof Sept 20 1946 (month) (day) (year)
Cemetery or crematory
Location: Washington D C
18. Funeral director: J. W. M. Lee & Sons
Address: 300-4th St N E

19. Sept. 19, 1946 (Date rec'd by registrar) Rowland S. Phibbs Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: SEPTEMBER 19 1946 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from JUNE 4 1946, to SEPT. 19 1946
and that I last saw h.i.m. alive on SEPT. 19 1946

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	6 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed 9/19/46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlee St., Baltimore 18

CERTIFICATE OF DEATH

09225 242

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Prince George's

City or town: Fort Washington

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 minutes

Hospital, institution, or street address where death occurred:

Vetrans Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Pomonky

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: William Walter Mack

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Nettie Mack

6.(c) If alive, give age: 20 years

7. Birth date of deceased (mo., day, yr.): October 23, 1922

8. AGE: Years	Months	Days	If less than one day
23	11	1	hrs. min.

9. Birthplace: Pomonky, Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER 12. Name: Robert Lee Mack

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Bessie Keys

MOTHER 15. Birthplace: Maryland

16. Informant: Leroy R. Mack

Address: Pomonky, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 28-46. (month) (day) (year)

Cemetery or crematory: Pomonkey - Md.

Location

18. Funeral director: John T. Rhoads & Co

Address: 961 - 3rd St. S.W.

19. 9-27.46 (Date rec'd by registrar) 19 Thos D. Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 24 19 46, at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death ..... DURATION

Hemorrhage and shock

Due to: Puncture wound in the skull

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Homocide Date of: 9/24/46

Where did injury occur? (City or town) Charles (County) Md. (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Struck with a pole Injured at work? No

23. SIGNATURE: Deputy Medical Examiner James L. Bond M. D. or other

Address: Forestville, Md. Date signed: 9/24/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09226

Reg. Diat. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos., 16 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 3 mos., 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: ..... County: .....

City or town: Washington, D. C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 300 - D. St. N. E.

(If rural, give LOCATION)

2.(a) If veteran, name war: –

3. (a) FULL NAME: BRUNO MANNI

3. (b) Social Security Number: 577-12-2842

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ida Manni

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): February 14, 1891

8. AGE: Years	Months	Days	If less than one day
55	7	6	..... hrs. ..... min.

9. Birthplace: Rome, Italy (Town, county, and state)

10. Usual occupation: Landscape Gardner

11. Industry or business:

FATHER — 12. Name: Vincent Manni

FATHER — 13. Birthplace: Rome, Italy

MOTHER — 14. Maiden name: Teressa Rosetti

MOTHER — 15. Birthplace: Rome, Italy

16. Informant: Decedent

Address:

17. burial (Burial, cremation, or removal. Which?) Date thereof: Sept 20 1946 (month) (day) (year)

Cemetery or crematory: St Mary's Cemetery

Location: Washington, D.C.

18. Funeral director: Frank Joy

Address: 570 C st, N.E., Washington DC

19. Sept 20, 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: SEPTEMBER 20 1946, at 7:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JUNE 4, 1946 to SEPT 20 1946

and that I last saw h... alive on SEPT. 20 1946

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	5 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. (M. D. or other)

Address: Glenn Dale, Md. Date signed: 9/20/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

09227

CERTIFICATE OF DEATH

Reg. Diat. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 days
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2407 - 15th St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: CATHERINE MANSFIELD

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Thomas B. Mansfield
6.(c) If alive, give age: 31 years

7. Birth date of deceased (mo., day, yr.): March 10, 1915

8. AGE:	Years	Months	Days	If less than one day
	31	6	-	...hrs. ...min.

9. Birthplace: Philadelphia, Pennsylvania
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: James Walsh
13. Birthplace: Ireland

MOTHER
14. Maiden name: Catherine O'Day
15. Birthplace: Ireland

16. Informant: Decedent
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept 10, 1946 (month) (day) (year)
Cemetery or crematory:
Location: to Washington, DC
18. Funeral director: Francis J. Collins
Address: 3821-14th St. NW. Wash. D.C.

19. Sept. 10, 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 10 1946, at 9:10 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 17 1946 to Sept 10 1946
and that I last saw her alive on Sept 10 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	5 mo
Due to: Miliary Type	25 da
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. (M. D. or other)
Address: Glenn Dale, Md. Date signed: 9/10/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40)

09223

CERTIFICATE OF DEATH

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County: Pro. Georges Co:-

City or town: Hyattsville Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Pro Geo Co:

City or town: Hyattsville Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3403 Longfellow st

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William Herman McCoy

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife: Era V. McCoy

6.(c) If alive, give age: 49. years

7. Birth date of deceased (mo., day, yr.): Oct 26. 1904.

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
42 41	-10	-26		

9. Birthplace: Washington D.C.

(Town, county, and state)

10. Usual occupation: Engineer

11. Industry or business: Washington Terminal

MOTHER FATHER

12. Name: Clarence McCoy

13. Birthplace: Washington D.C.

14. Maiden name: Sadie V. Johnson

15. Birthplace: Dickerson Md:-

16. Informant: Mrs Era V. McCoy:-

Address: Hyattsville Md.:-

17. (Burial, cremation, or removal. Which?) Burial:- Date thereof: Sept 24 1946-

Cemetery or crematory: Cedar Hill Cemetery:-

Location: Suitland Md

18. Funeral director: E Gaschi sons

Address: Hyattsville Md.:-

19. Sept. 23 1946 (Date rec'd by registrar) Mrs Jas Devere Registrar Deputy Clerk

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 21. 1946, at 2 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/8 1946, to 9/21 1946

and that I last saw h~~im~~ alive on 9/21 1946

	DURATION
Immediate cause of death: Coronary occlusion	8 hr
Due to: Coronary artery disease	3 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C Louis Mendel, M D

M. D. or other

Address: College Park Md Date signed: 9/21/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-D

09224

CERTIFICATE OF DEATH

Reg. Dist. No. 745

1. PLACE OF DEATH:
County Pro. Geo. County
City or town Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs
Hospital, Institution, or street address where death occurred:
Mother Jones Rest Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Pro Geo co
City or town Riverdale Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5000 Rittenhouse st
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Grace Estelle Mc Knew

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 3. 1887

8. AGE: Years 59 | Months | Days | If less than one day hrs. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual occupation Retired - Dressmaker

11. Industry or business

FATHER
12. Name Nathan Luskey Mc Knew
13. Birthplace Md

MOTHER
14. Maiden name Cora Young
15. Birthplace Md

16. Informant Nathan Mc Knew
Address Riverdale Md

17. Burial Date thereof Sept 21, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Western Cemetery
Location Baltimore Md
18. Funeral director F. Gesche's sons
Address Hyattsville Md.

19. Sept 20 1946 James Savey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18. 1946 at 5.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/9/46 to 9/18/46
and that I last saw h[illegible] alive on 9/17/46

	OURATION
Immediate cause of death Hypostatic Pneumonia	2 days
Due to Rt Hemiplegia	2 wks.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Dr Ruppert & H T Morse (M.D)
Address 7 Carrollton, Takoma Park, Md M. D. or other
Date signed 9/19/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09228

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 1 mos., 15 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 yr., 1 mo., 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: ..... County: .....
City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 34 E. Street N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: MILLER, JOSEPH

3.(b) Social Security Number: 247-24-7526

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Annie Lou Miller
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): March 28, 1904

8. AGE: Years	Months	Days	If less than one day
42	5	21	..... hrs. ..... min.

9. Birthplace: Edgefield, South Carolina (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Government

FATHER
12. Name: Wiley Miller
13. Birthplace: Edgefield, South Carolina

MOTHER
14. Maiden name: Mary Birt
15. Birthplace: Edgefield, South Carolina

16. Informant: Decedent
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept. 18, 1946 (month) (day) (year)
Cemetery or crematory
Location: to Washington, D.C.

18. Funeral director: Henry S. Washington & Sons
Address: 469 N. St. N.W., Wash. D.C.

19. Sept. 18, 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 18, 1946, at 7:20 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/3/45 to 9/18/45 and that I last saw him alive on 9/18/45

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 15 mos.
Due to:
Complication: Tuberculosis of Left Knee — 9 mo
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Tuberculosis of left tibia during arthrodesis of left knee. Date of op. 7/29/46
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale Md. Date signed: 9/18/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (134a)

CERTIFICATE OF DEATH

09229

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince George

City or town: Cottage City Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 3714 - 37th Ave

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 20 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Prince George

City or town: Cottage City Md. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 3714 37th. Ave.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Hester Nancy Montgomery

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife: ----

6(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 3, 1871

8. AGE: Years	Months	Days	If less than one day
74	8		____ hrs. ____ min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: James M. Montgomery

13. Birthplace: Va.

MOTHER — 14. Maiden name: Clara Jones

15. Birthplace: N.Y.

16. Informant: Florence E. Dean

Address: 3714 37th. Ave. Cottage City

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 4, 1946 (month) (day) (year)

Cemetery or crematory: Fort Lincoln

Location: Bladensburg Md.

18. Funeral director: Deal Funeral Home

Address: 4812 Georgia Ave. N. W. D.C.

19. 9/2 (Date rec'd by registrar) 1946 Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 1 1946, at 2:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h__ alive on ____ 19__.

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Deputy medical examiner James L. Long M. D. or other

Address: Forestville Md. Date signed 9-2-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (86-a)

CERTIFICATE OF DEATH

09230

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince George

City or town Riverdale, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 53 days

Hospital, institution, or street address where death occurred:
Leland Memorial Hospital-Queensbury Rd.

How long in hospital or institution? 53 days. Riverdale, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Greenbelt
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7D Southway Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

(Mrs). Mary Moore

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed.

6.(b) Name of husband ~~or wife~~ James Gibson Moore

6.(c) If alive, give age Deceased years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1874

8. AGE: Years	Months	Days	If less than one day
71	10	5	....hrs. ....min.

71 1874 Nov. 17

9. Birthplace Philadephia, Penna. (Town, county, and state)

10. Usual occupation House Wife

11. Industry or business House wife

FATHER
12. Name Joseph Rawbottom
13. Birthplace England.

MOTHER
14. Maiden name Matilda Crabtree
15. Birthplace England.

16. Informant James Rawbottom Moore (Son)

Address 7D. Southway Rd. Greenbelt Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 25, 1946 (month) (day) (year)

Cemetery or crematory Fort Lincoln

Location colmar manor md

18. Funeral director F Gaeta's sons

Address Hyattsville Md

19. Sept. 25 1946 Mrs. Jas. Severe Deputy Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22, 1946, at 3:19 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1, 1946 to ~~Oct~~ Sept. 22, 1946

and that I last saw h.. alive on Sept. 22 1946

Immediate cause of death Fractured rt femur DURATION

osteomyelitis, terminal pneumonia

edema, septicemia

Due to Accidental fall—fell out of bed. Surgery.

Due to

Other conditions Anemia undetermined origin

Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Absent

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of August 2, 1946

Where did injury occur? Eugene Leland Memorial Hospital, Riverdale (City or town) Prince Georges (County) Maryland. (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Leeland H Mckenney M. D. or other

Address Riverdale Md. Date signed Sept 23 '46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09231

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Md., - Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs., 10 mo's. 25 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 2 yrs., 10 mo's, 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1208- D. St., S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: -

3.(a) FULL NAME: Wilbert Moss

3.(b) Social Security Number: 579-14-1411

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	colored	single

6.(b) Name of husband or wife: [illegible]

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 23, 1913

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
33	6	-		

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: short-order cook

11. Industry or business: -

FATHER
12. Name: ? Moss
13. Birthplace: Unknown

MOTHER
14. Maiden name: Eva Green
15. Birthplace: Sacred Heart, Maryland

16. Informant: deceased

Address:

17. removal (Burial, cremation, or removal. Which?) Date thereof: Sept 23 1946 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: W. Earl Bettes

Address: 1203 Walter St, S.E. Wash, D.C.

19. Sept 22, 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9 - 22 19 46 at 5 p.m. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 10-27 19 43 to 9-22 19 46

and that I last saw him alive on 9-22 19 46

Immediate cause of death	DURATION
Pulmonary Tuberculosis	6 9 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 9/22/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

09232

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (934)

CERTIFICATE OF DEATH

Reg. Dist. No. 242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: Pr. Geo. Co.
County: Croome Settlement Md.
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred: Croome Settlement
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Pr. Geo.
City or town: Croome (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Mary Ella Mossell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1840

8. AGE: Years: 106 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Kentucky (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Ella Johnson
15. Birthplace: Kentucky

16. Interment: Myrtle Henry
Address: 1233 Irving St. N.W.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept. 12 46 (month) (day) (year)

Cemetery or crematory:
Location:

18. Funeral director: Arthur L. Rollins
Address: 4339 - Hunt Pl. N.E.

19. Sept. 12 1946 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 11 1946 at 10:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1945 to Sept 11 1946
and that I last saw h alive on Sept. 11 1946

Immediate cause of death	DURATION
Congestive Heart Failure	2 months
Due to: Myocarditis	5 yrs
Due to:	
Other conditions: Arteriosclerosis	15 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op.

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: James C. Spencer M. D. or other
Address: Upper Marlboro, Md Date signed: 9-12-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

09233 Reg. Dist. No. 239

1. PLACE OF DEATH:
County: Prince Geo. Co
City or town: Laurel - md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: ✓
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: md County: Pr. Geo. Co
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 305 - 2nd St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Catherine M. Moynihan

3.(b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife: Frank Moynihan
6.(c) If alive, give age: ✓ years

7. Birth date of deceased (mo., day, yr.): Sept - 19 - 1869

8. AGE: Years	Months	Days	If less than one day
76			hrs. min.

9. Birthplace: Newark N J (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER 12. Name	Wm Kiernan
FATHER 13. Birthplace	N J
MOTHER 14. Maiden name	Anna Gillick
MOTHER 15. Birthplace	Ireland

18. Informant: Frank A Moynihan Address: 305 - 2nd St Laurel md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 7 - 46 (month) (day) (year)
Cemetery or crematory: St. Mary's Cemetery
Location: Laurel, Md

18. Funeral director: Low Chambers Co
Address: Riverdale - Md

19. Sept 5 1946 (Date rec'd by registrar) M. Brashears Registrar
Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 5 1946, at 11 o'clock P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 7 - 1946, to Sept 5 1946
and that I last saw her alive on Sept 5 1946

Immediate cause of death	DURATION
Carcinoma Stomach	7
Metastasis Cardiac End	1
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D., or other
Address: Laurel Date signed: 9/7/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48)

09234

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, Institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County:

City or town: Washington D. C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 413 - 10th St. N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mrs Elsie Madelin Nail

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband ~~or wife~~: Mr George Edward Nail

Nov 3 - 1898 6.(c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Nov. 3 - 1898

8. AGE: Years	Months	Days	If less than one day
47	9	29	..... hrs. ..... min.

9. Birthplace: St. Mary Co. Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: Alexander Carter Worthington

13. Birthplace: Maryland

MOTHER 14. Maiden name: Ella May Owens

15. Birthplace: Maryland

16. Informant: Chart

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 4 1946 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Suitland Md

18. Funeral director: Deal Funeral Home

Address: 4812 Ga. ave. N.W. D.C.

19. Sept 3 1946 James Seery

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-2 1946, at 10:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 27 1946, to Sept 2 1946

and that I last saw h. w. alive on Sept 2 1946

Immediate cause of death	DURATION
Pneumonia	
Due to: Carcinoma of Uterus	
Due to: invasion into bladder	
Other conditions: septicemia metastasis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Rowland F Wilkinson MD (M. D. or other)

Address: Rivrdale Md Date signed: 9-2-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

09235 230

CERTIFICATE OF DEATH

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Georges Co.
City or town: Berwyn Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Berwyn
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME: Annie P. Olinger

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Wm Edward Olinger
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 4, 1864.

8. AGE: Years	Months	Days	If less than one day
82	6	23	hrs. min.

9. Birthplace: Washington D.C.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home
FATHER 12. Name: William H Braund
13. Birthplace: England
MOTHER 14. Maiden name: Agnes Peet
15. Birthplace: England
16. Informant: Mrs. Anna G. Williams
Address: 3901-52nd St Hyattsville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 30 1946 (month) (day) (year)
Cemetery or crematory: Congressional Cemetery
Location: Washington, D.C.
18. Funeral director: Martin W. Hysong Co
Address: 1300 N. St N.W. Wash. D.C.
19. Sept 27 1946 (Date rec'd by registrar) Mrs Stacia Severe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 27 1946, at 10:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Many years to Septr 27 1946 and that I last saw h... alive on Sept 1946

Immediate cause of death	DURATION
Coronary Thrombosis	6 days
Due to: Chronic Myocarditis	Several years
Due to: Arteriosclerosis	Several years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work?

23. SIGNATURE: W. Allen Griffith M. D. or other
Address: Berwyn Md Date signed: 9/29/46

Evidence for change of date of death and date of accident shown on Film G107 9/20/46 dm

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (169)

CERTIFICATE OF DEATH

09236

Reg. Dist. No. 240

1. PLACE OF DEATH:

County Prince Georges

City or town Brandywine

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Permanent

Hospital, Institution, or street address where death occurred: Railroad tracks

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Brandywine

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Clarence Dutton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

B.(b) Name of husband or wife Carry E. Dutton

6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Sept 16, 1888

8. AGE: Years 57 Months 11 Days 27 If less than one day ..... hrs. ..... min.

9. Birthplace Delaware (Town, county, and state)

10. Usual occupation Station Agent

11. Industry or business Railroad

FATHER 12. Name Seth P. Dutton

FATHER 13. Birthplace Delaware

MOTHER 14. Maiden name Unknown

MOTHER 15. Birthplace Unknown

16. Informant Wilma A. Crawford

Address Indian Head, Md.

17. Burial (Burial, cremation, or removal, which?) Date thereof 9-16-46 (month) (day) (year)

Cemetery or crematory St. Thomas Church

Location Christian, Md.

18. Funeral director Pitcher Bros.

Address Upper Marlboro, Md.

19. Sept 14 1946 (Date rec'd by registrar) F. H. Billingsley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 13 1946 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Hemorrhage and shock	
Due to Cut in two by train passing over body	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 13

Accident, suicide, or homicide Accident Date of 9-14-46

Where did injury occur? Brandywine (City or town) P.G. (County) Md. (State)

Injured at home, farm, industry, public place (where?) R.R. tracks

Means of injury Run over by train Injured at work? Yes

23. SIGNATURE Deputy medical Examiner M. D. or other

Address Westwood Md. Date signed 9-16-46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09237

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's Co.
City or town: (Rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3117 Georgia Ave., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: PARR Joseph

3.(b) Social Security Number: 579-14-5268

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Emma Parr
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): November 6, 1877

8. AGE: Years	Months	Days	If less than one day
68	10	1	...hrs. ...min.

9. Birthplace: Westmorland, Virginia
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: American Window Cleaning Co.

FATHER
12. Name: Ezekial Parr
13. Birthplace: Virginia

MOTHER
14. Maiden name: Lucinda Quarles
15. Birthplace: Virginia

16. Informant: Decedent
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept. 9, 1946 (month) (day) (year)

Cemetery or crematory:
Location: to Washington, D. C.

18. Funeral director: W Ernest Jamison
Address: 1432 yuma st N.W.

19. Sept 7, 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-7 1946, at 4 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-6, 1946, to 9-7 1946
and that I last saw him alive on 9/6 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	6 mo.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Bilateral pulmonary tuberculosis and tuberculous entero-colitis, tuberculous bronchitis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 9/7/46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09238

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Prince Georges.
City or town: Riverdale (If outside city or town limits, write RURAL and give nearest town) s.e. Md.
How long in above place of death? 4 1/2 hrs.
Hospital, institution, or street address where death occurred: Leland Memorial Hospital.
How long in hospital or institution? 4 1/2 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince Georges
City or town: Riverdale (If outside city or town limits, write RURAL and give nearest town)
Street No. 6201 - 44th ave (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Pierce Mrs Jennie R.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed.

6.(b) Name of husband or wife: Russel E. Pierce
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 6. 1850

8. AGE: Years	Months	Days	If less than one day
96	4	21	..... hrs. ..... min.

9. Birthplace: Chenago Co., N. York (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Housewife
FATHER 12. Name: Solomon Conver
FATHER 13. Birthplace: Chenago Co. N. York.
MOTHER 14. Maiden name: Roxie Jane Stoddard
MOTHER 15. Birthplace: Chenago Co. N. York
16. Informant: Ethel P. Persons daughter
Address: 6201 - 44th Av. Riverdale
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 30 1946 (month) (day) (year)
Cemetery or crematory: Fort Lincoln Mem. Cem.
Location: Riggs Rd.
18. Funeral director: J. Arthur Walters Takoma Park D.C.
Address: 25 Carroll St. N.W.
19. Sept 27 1946 (Date rec'd by registrar) Mrs. Jas. Severe Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 27 1946 at 4:40 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 19 1946 to Sept 27 1946 and that I last saw h.. alive on Sept 27 1946

Immediate cause of death	DURATION
terminal pulmonary congestion + bronchopneumonia	
Due to: Advanced age	
arteriosclerosis	
Due to: malnutrition	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Leland Memorial Hosp. M. D. or other
Address: 4404 Gunnerbury Rd Riverdale Md. Date signed: 9-27-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County PR. GEO
City or town LANDOVER
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County PR. GEO
City or town LANDOVER
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME BABY PINKNEY

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	COL	SINGLE

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 26, 1946

8. AGE: Years | Months | Days 12 | If less than one day hrs. min.

9. Birthplace WASH. D.C. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name JOHN PINKNEY
13. Birthplace MD.

MOTHER 14. Maiden name HELEN HYLES
15. Birthplace D.C.

16. Informant JOHN PINKNEY
Address LANDOVER, MD.

17. (Burial, cremation, or removal. Which?) Removal Date thereof Sept. 8, 1946 (month) (day) (year)
Cemetery or crematory Payne's Cemetery
Location Washington, D.C.

18. Funeral director John T. Stewart
Address Ga. & Hyatt

19. Sept. 9 1946 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT 8 1946 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 2 1946 to Sept 7 1946 and that I last saw h. alive on Sept 7 1946

Immediate cause of death	DURATION
Dysentery	11 days
Due to Diarrhea	
Due to	
Other conditions Pneumonia	
Dehydration	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. C. Belden M.D.
M. D. or other
Address 4423 Hunt Pl. N.E. Date signed 9-8-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

NAME: DOCTOR'S STATEMENT FILED 10-15-46 G107 LL 09240

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County PRINCE GEORGE
City or town VETS ADM.HOSP. FT WASH,Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since 6-4-46 #3months
Hospital, institution, or street address where death occurred:
Vets Adm Hospital,Fort Washington Md.
How long in hospital or institution? About 2 yrs(Mt Alto .VAH)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Virginia County Prince William
City or town Occoquan
(If outside city or town limits, write RURAL and give nearest town)
Street No. None
(If rural, give LOCATION)
2.(a) If veteran, name war Spanish American

3. (a) FULL NAME
JOHN REDMOND SELECMAN / ROBERT SELECMAN

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife MINNIE Allen Selectman Selecman
6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) May 26,1878

8. AGE: Years	Months	Days	If less than one day
68	3	7	....hrs. ....min.

9. Birthplace OCCUQUAN Va
(Town, county, and state)
10. Usual occupation Supt. Brick yard
11. Industry or business D.C.gov't
FATHER 12. Name Thomas R Selectman Selecman
13. Birthplace Occuquan
MOTHER 14. Maiden name Unknown
15. Birthplace

16. Informant R.W.Hall Son-in-law
Address Occuquan Va
17. Removal Sept 3 1946 Date thereof 9-3-46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Pohich Va
Location Lorton Va
18. Funeral director Hall Funeral Home
Address OCCUQUAN Va
19. Sept. 3 1946 Carrie Campbell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 3rd 1946, at 12.04 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 4th,1946 1946, to Sept 3rd 1946
and that I last saw him alive on Sept 2nd ,1946 1946

Immediate cause of death	DURATION
Pneumonia,hypostatic	
Due to Multiple cerebral accidents	
Due to Hypertension & arteriosclerosis Gen	
Other conditions Hypertensive and arteriosclerot -ic Heart Disease	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Chas P Benson MD CHAS. P. BENSON, MD M. D. or other
Address Vets Adm Hospital for workmen Date signed 9-3-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157d

09241

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH:

County: Prince Georges

City or town: Laurel Hospital Bladg S. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: County:

City or town: (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Lewis Smyers

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) July 20, 1946

8. AGE: Years | Months 2 | Days 1 | If less than one day: hrs. min.

9. Birthplace: Washington, D.C. (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER — 12. Name: Robert Paine Smyers

FATHER — 13. Birthplace: Penn.

MOTHER — 14. Maiden name: Mary C. Seal

MOTHER — 15. Birthplace: Washington D.C.

16. Informant: Mrs Harold Weld

Address: 6116 - 33rd St. N. W. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9 - 25 - 46 (month) (day) (year)

Cemetery or crematory: Rock Creek Cemetery

Location: Washington, D.C.

18. Funeral director: Martin W. Hysong Co.

Address: 1300 N. St. N.W. Wash D.C.

19. Sept 24 1946 M. Brashears (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 24 1946, at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 23 1946, to Sept 24 1946

and that I last saw him alive on Sept 24 1946

Immediate cause of death	DURATION
Congenital Malformation (#167a)	2 mo
Due to: No further information concerning the malformations C.M.O.	
Due to:	
Other conditions: Bronchopneumonia	29

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert S McInerney M.D. (M. D. or other)

Address: Laurel Md Date signed: 9/24/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

09242 345

Reg. Diat. No.

1. PLACE OF DEATH:
County: Prince Geo.
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 hrs. 40 min.
Hospital, institution, or street address where death occurred: Leland Memorial Hospital
How long in hospital or institution? 6 hrs. 40 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 824-Upshur St-N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Eugene George Stanley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna Stanley
6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): July-29-1875

8. AGE: Years	Months	Days	If less than one day
71	1	8	....hrs. ....min.

9. Birthplace: Norristown-Pa. (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: Mathew Stanley
13. Birthplace: Pa.

MOTHER
14. Maiden name: Sarah George
15. Birthplace: Pa.

16. Informant: Anna Stanley
Address: Washington-D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept 6 1946 (month) (day) (year)
Cemetery or crematory:
Location: Washington D.C.
18. Funeral director: Deal Funeral Home
Address: 4812-Georgia Ave-N.W.Wash-D.C.

19. Sept 6 1946 (Date rec'd by registrar) James Devey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 6, 1946, at 4 20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18, 1940, to September 6 1946
and that I last saw him alive on September 5 1946

Immediate cause of death	DURATION
Cerebral accident	1day
Due to: Hypertensive cardiac disease	Unknown
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Geo G Stadler M.D. or other
Address: 1252-6th-St-S.W. Washington-D.C. Date signed: 9/6/46

M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

09243

CERTIFICATE OF DEATH

Reg. Diat. No. 245

1. PLACE OF DEATH:
County Prince George
City or town Rural Hyattsville Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Mother Jones Rest Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D C County
City or town Washington D C
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Robert Stewart

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Maine Stewart
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 14th 1862

8. AGE: Years	Months	Days	If less than one day
84	6	23	..... hrs. ..... min.

9. Birthplace Washington D C (Town, county, and state)
10. Usual occupation Retired
11. Industry or business Postal Clerk
FATHER 12. Name Thomas Stewart
FATHER 13. Birthplace N. Y.
MOTHER 14. Maiden name Antoinette Holmes
MOTHER 15. Birthplace Spain
16. Informant Mr Thomas R Stewart
Address 9408 - 2nd ave Silver Spring Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 11th 1946 (month) (day) (year)
Cemetery or crematory Congressional Cemetery
Location Washington D C
18. Funeral director J Wm Lee Sons Co
Address 360 - 4th St N E.
19. 9/10 46 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 Sept. 1946 at 12 noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 August 1946 19.. to 8 Sept 19.46 and that I last saw h.. alive on 5 Sept. 19.46.

	DURATION
Immediate cause of death Respiratory failure	4-6 hrs.
Due to Cerebral Hemorrhage	15 Days.
Due to Senile Arteriosclerosis	Many years.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation — Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE H H Queen M.D.
M. D. or other
Address Takoma Park, Md. Date signed 9 Sept. 46.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09244

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 mos. 5 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 5 mos., 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 813 - 22nd St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: URSAHINE STROMAN.

3.(b) Social Security Number: 578-36-2590

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife: -
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 3, 1929

8. AGE: Years	Months	Days	If less than one day
17	1	6	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Counter Girl
11. Industry or business: Restuarant

FATHER
12. Name: James Stroman
13. Birthplace: Orangeburg, South Carolina

MOTHER
14. Maiden name: Mary Walker
15. Birthplace: Washington, D. C.

16. Informant: Decedent
Address:
17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept. 9, 1946 (month) (day) (year)
Cemetery or crematory:
Location: to Washington, D.C.
18. Funeral director: Joseph Janifer
Address: 1138-22 St N.W.
19. Sept. 9 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION 4-40 A M

20. DATE OF DEATH: Sept. 9th 1946, at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 4th 1946, to Sept 9th 1946, and that I last saw her alive on Sept 9th 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	8 mos.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 9/9/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09245

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince Georges

City or town Cheverly (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Prince Georges General Hospital

How long in hospital or institution? 5 hours 30 min

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Prince Georges

City or town College Park (If outside city or town limits, write RURAL and give nearest town)

Street No. 7212 Bowdoin Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James W. Suit

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 1, 1946.

8. AGE: Years | Months 5 | Days 22. | If less than one day hrs. min.

9. Birthplace Cheverly Prince Georges Md. (Town, county, and state)

10. Usual occupation None.

11. Industry or business

FATHER 12. Name Eugene Suit

13. Birthplace Md

MOTHER 14. Maiden name Rose Talbott

15. Birthplace Md.

16. Informant Rose M. Suit.

Address 7212 Bowdoin Ave Col. PK. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 25, 1946. (month) (day) (year)

Cemetery or crematory Mt. Oliret.

Location Wash. D.C.

18. Funeral director W. W. Chambers Co.

Address Riverdale, Md.

19. 9/24 1946 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23, 1946, at 11 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Septemb 23 1946, to Sept. 23 1946 and that I last saw h... alive on Sept. 23. 1946.

	DURATION
Immediate cause of death Toxemia due to Acute Broncho pneumonia	Several hours
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Acute broncho Pneumonia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. D. or other

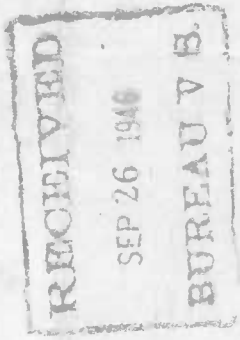
Address Riverdale Md Date signed 9/25/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Coroners autopsy
and verdict appended



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24)

09245

CERTIFICATE OF DEATH

Reg. Diat. No. 231

1. PLACE OF DEATH:
County: Dist Geo Co
City or town: Cheverly Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Dist Geo General hospital
How long in hospital or Institution? 24 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Dist Geo Co
City or town: 3702 Windom Rd,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Brentwood Md
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Gussie Sward

3. (b) Social Security Number

4. Sex: F
5. Color or race: Wh
6.(a) Single, married, widowed, or divorced: widowed
6.(b) Name of husband or wife: Edward Sward
8.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Feb 15 1884
8. AGE: Years: 60 Months: 11 Days: 13 If less than one day: ... hrs. ... min.
9. Birthplace: Ga (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Edward Cowan
13. Birthplace: Ga
MOTHER 14. Maiden name: Virginia Lee
15. Birthplace: Ga.
18. Informant: Frank Sward
Address: 3702 Windom Rd Brentwood Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 5, 1946 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland Md
18. Funeral director: Frances Gaddis Jones.
Address: Hyattsville Md.
19. 9/4 1946 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 2 1946, at ... M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1944 to Sept 2 1946 and that I last saw her alive on Sept 2 1946

Immediate cause of death	DURATION
Arteriosclerotic Hypertension Heart disease	2yrs. +
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy result: Cardiac Hypertrophy, Hilary cirrhosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ... Injured at work?

23. SIGNATURE: Irvin R. Evergreen M.D. M. D. or other
Address: 2503 Queens Chapel Rd Mt. Rainier Date signed 9-2-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09247

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mos.
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 3 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1919 - 9th St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: RICHARD A. TANNER

3.(b) Social Security Number: 577-10-4166

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Separated

6.(b) Name of husband or wife: Ethel H. Tanner
6.(c) If alive, give age? years

7. Birth date of deceased (mo., day, yr.): November 22, 1915

8. AGE: Years	Months	Days	If less than one day
30	9	10	hrs. min.

8. Birthplace: Charlotte, North Carolina (Town, county, and state)
10. Usual occupation: Assist. Cook
11. Industry or business: Hotels

FATHER
12. Name: Horace Tanner
13. Birthplace: Matthew, North Carolina

MOTHER
14. Maiden name: Saphronia Davidson
15. Birthplace: Matthew, North Carolina

16. Informant: Decedent
Address: ~~Removal~~

17. (Burial, cremation, or removal. Which?) Date thereof 9-4-46 (month) (day) (year)
Cemetery or crematory: removal
Location: Wash. D.C. 8/22/46
18. Funeral director: Johnson & Jenkins
Address: 2053 Fee Ave N.W, Wash. D.C.
19. Sept 1, 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 1, 1946, at 9:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1946, to Sept 1, 1946
and that I last saw him alive on Sept 1, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4 mo
Due to	12 da
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed 9/1/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

09248

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH:

County Prince Georges

City or town Maryland Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:
109-65th Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 109-65th Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Arthur Thomas

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife Mary Thomas

6.(c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) March 19, 1876

8. AGE: Years 70 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER — 12. Name William Thomas

13. Birthplace Maryland

MOTHER — 14. Maiden name Margaret Elizabeth Windsor

15. Birthplace Maryland

16. Informant Mrs Annie Moreland

Address 109-65th Street, Maryland Park, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9 22 46 (month) (day) (year)

Cemetery or crematory St Thomas

Location Croom and Ritchie Brothers

18. Funeral director Ritchie Brothers

Address Upper Marlboro and Forestville Md

19. Sept 21 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1946, at 9:22 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1938, to Sept 19 1946

and that I last saw h... alive on Sept 16 1946

Immediate cause of death ... DURATION

Uremia

Due to Cardiovascular renal disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James L Boyd M. D. or other

Address Forestville Md Date signed 9-19-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ Reg. Diat. No. 09245 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 11mos., 29 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 yr., 11 mos., 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1435 Irving St. N. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3. (a) FULL NAME: PAUL THOMPSON

3. (b) Social Security Number: ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Separated

6.(b) Name of husband or wife: Elizabeth Thompson
6.(c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): July 31, 1912

8. AGE:

Years	Months	Days	If less than one day
34	1	3	...hrs. ...min.

9. Birthplace: Goldsborough, North Carolina
(Town, county, and state)

10. Usual occupation: Baker

11. Industry or business:

FATHER
12. Name: Henderson, Thompson
13. Birthplace: Goldsborough, North Carolina

MOTHER
14. Maiden name: Eunice Howard
15. Birthplace: Goldsborough, North Carolina

18. Informant: Decedent
Address:

17. Removal to Wash. D.C. Date thereof: 9/3/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory:
Location:

18. Funeral director: W. Ernest Jarvis Co.
Address: 1432-You St. N.W. Wash. D.C.

19. Sept 3 19 46 Rowland S. Phibbs
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-3-46 19... at 7.20 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-5 19 46, to 9-3 19 46
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: PULMONARY TUBERCULOSIS	2 yrs
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: Sept 3, 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85a)

09250

CERTIFICATE OF DEATH

Reg. Dist. No. 240

1. PLACE OF DEATH:
County Prince Georges
City or town Cheltenham
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Cheltenham
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME J. Frank Tippett sr.

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of ~~husband~~ or wife Q. Irene Tippett
6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Oct 26 1873

8. AGE:

Years	Months	Days	If less than one day
72	—	—	....hrs. ....min.

9. Birthplace Prince Georges Co. (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business Own Farm
FATHER 12. Name J. Frank Tippett
FATHER 13. Birthplace Unknown
MOTHER 14. Maiden name Margaret Torrent
MOTHER 15. Birthplace Maryland
16. Informant Q. Irene Tippett
Address Cheltenham, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9 5 46 (month) (day) (year)
Cemetery or crematory Leyte Upham
Location Cheltenham Md.
18. Funeral director Peter Brothers
Address Upper Marlboro Md
19. Sept 4 1946 F. H. Billingsley (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3 1946, at 9 15 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 25 1946, to Sept 3 1946
and that I last saw him alive on Sept 2 1946

	DURATION
Immediate cause of death: Cerebral Hemorrhage	1 Week
Due to: General Arteriosclerosis	Unknown
Due to: —	
Other conditions: Enlarged Prostate	Unknown
Gland - Senile Type	

(Include pregnancy within 3 months of death)

Major findings of operation none Date of op. —
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide — Date of —
Where did injury occur? none (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? none

23. SIGNATURE Paul E. Van Hatten M. D. or other
Address Washington 19 DC Date signed Sept 3 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

09251

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince Georges Co:
City or town: College Park Md:
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Pr Geo co:
City or town: College Park Md:
(If outside city or town limits, write RURAL and give nearest town)
Street No.: University Lane:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mary Maria Voytko

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: John Voytko
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Sept 10. 1877.

8. AGE: Years: 69 | Months: — | Days: — | If less than one day: hrs. min.

9. Birthplace: Storog Hungary (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: John Papp.
13. Birthplace: Hungary

MOTHER
14. Maiden name: Susanna Stirz
15. Birthplace: Hungary

16. Informant: Irma Voytko
Address: College Park Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 23. 1946 (month) (day) (year)
Cemetery or crematory: Geo washington Cemetery
Location: Hyattsville Md
18. Funeral director: L Gaschè sons
Address: Hyattsville Md.

19. Sept 20 1946 (Date rec'd by registrar) James Sevey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 19, 1946 at 1.45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30 1945 to Sept 19 1946
and that I last saw h.. alive on Sept 18, 1946.

Immediate cause of death	DURATION
Cerebral Thrombosis	3 days.
Due to: Cardio vascular renal disease	3 Yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: L A Mahon MD (M. D. or other)
Address: Beverdale, md Date signed: 9-19-46.

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age of deceased is shown on

09252

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

FILM No. I 07 OCT 8 1946

CERTIFICATE OF DEATH

Reg. Diat. No. 231

1. PLACE OF DEATH:

County: Prince Georges

City or town: Oxon Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: District of Columbia County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 518 - 4th Street S. E.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Earl Nathaniel Ward

3.(b) Social Security Number 219-12-3619

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	married

6.(b) Name of husband or wife: Thelma Brooker

6.(c) If alive, give age: 17 years

7. Birth date of deceased (mo., day, yr.): Oct 20, 1924

8. AGE: Years	Months	Days	If less than one day
22			hrs. min.

9. Birthplace: Washington D.C. (Town, county, and state)

10. Usual occupation: Truck Driver

11. Industry or business: Hauling

FATHER 12. Name: Earl Ward

13. Birthplace: Maryland

MOTHER 14. Maiden name: Ella Preston

15. Birthplace: Maryland

16. Informant: Mary H. Benton

Address: 324 - 26th St N.E. Wash. D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept 18, 1946 (month) (day) (year)

Cemetery or crematory: Washington Funeral Home

Location: 467 N St N.W. Washington D.C.

18. Funeral director: F. Gosch's Sons

Address: Hyattsville Md

19. Sept 15 19 46 (Date rec'd by registrar) Amanda Dowray Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 15 19 46 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.., to ..... 19..

and that I last saw h... alive on ..... 19..

Immediate cause of death	DURATION
Hemorrhage and Shock	
Due to Fracture of skull Crushed chest	
Due to Automobile accident; collision with another automobile.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of

Where did injury occur? Indian Head Road, Oxon Hill, Maryland (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy medical Examiner

23. SIGNATURE: Thomas J. Ford M. D. or other

Address: Forestville Md Date signed 9-15-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

09253

CERTIFICATE OF DEATH

Reg. Dist. No. 242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George
City or town: Temple Hills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mo
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Temple Hills Washington 20 D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7921 Temple Hills Road.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Virginia Gertrude Watts

3.(b) Social Security Number: Unknown.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	White	Widowed

6.(b) Name of husband or wife: Harvey Nathaniel Watts
6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): July 25 1885

8. AGE: Years 61 | Months 1 | Days 7 | If less than one day: ... hrs. ... min.

9. Birthplace: Washington D.C. (Town, county, and state)
10. Usual occupation: Forewoman Land Clerk Census
11. Industry or business: U.S. Census Suitland Md.
FATHER 12. Name: Walter Sumpter
13. Birthplace: Washington D.C.
MOTHER 14. Maiden name: Ann Rebecca Hardy
15. Birthplace: Washington D.C.
16. Informant: Gladys I. Hallinger
Address: 4921 Temple Hills Rd - D.C. 20.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 5, 1946 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cemetery
Location: Washington, D.C.
18. Funeral director: James F. Ryan Inc.
Address: 317 Penna. Ave., S.E.
19. Sept-3 1946 (Date rec'd by registrar) Thos D. Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 2 1946, at 7:03 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 13 1946, to Sept 2 1946
and that I last saw her alive on Sept 1 1946

Immediate cause of death	DURATION
Carcinoma of left Breast with	7 mo.
Due to metastases	
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide: No Date of: —
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work?

23. SIGNATURE: Paul O. Watts M. D. or other
Address: Washington 19 D.C. Date signed: Sept 2 1946.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (151-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 0925 2230

1. PLACE OF DEATH:
County: Prince George
City or town: Greenbelt, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months, 11 days
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Greenbelt
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4-D Plateau Pl.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: CARL LEWIS WETTER

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 18, 1946

8. AGE: Years: — Months: 5 Days: 21 If less than one day: hrs. min.

9. Birthplace: Riverdale, Prince George, Md (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER — 12. Name: Arthur Wetter
13. Birthplace: New York, N.Y.

MOTHER — 14. Maiden name: Tillie Goodfarb
15. Birthplace: New York, N.Y.

16. Informant: Arthur Wetter, father
Address: 4-D Plateau Pl. Greenbelt, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 10 1946 (month) (day) (year)
Cemetery or crematory: National Hebrew Cemetery
Location: Bennings, D.C.

18. Funeral director: Goldberg Funeral Home
Address: 4217 - 9th St. N.W.

19. Sept 8 1946 (Date rec'd by registrar) Officer J. E. Allen. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 8 1946, at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 18, 1946 to Sept. 7, 1946 and that I last saw h.. alive on September 7, 1946

	DURATION
Immediate cause of death: Congestive Heart failure	1 day
Due to: Congenital heart disease	5 m. 21 d.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Hans Woolak, M.D.
M. D. or other
Address: 30-D Ridge Rd, Greenbelt, Md. Date signed: 9-8-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-a)

09255

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince Georges
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 yrs.
Hospital, Institution, or street address where death occurred: 7213 Flower Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince Georges
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7213 Flower Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: LEONA HENRIETTA WHITE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	WIDOWED

6.(b) Name of husband or wife: FRANK WHITE
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1872

8. AGE:

Years	Months	Days	If less than one day
74	7	—	..... hrs. ..... min.

9. Birthplace: (Town, county, and state)
10. Usual occupation: At Home
11. Industry or business: Own Home.

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name: Sallie Furman Oliver
15. Birthplace: Kansas

18. Informant: Mrs. Leona Hamilton
Address: Newport News, Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 11, 1946. (month) (day) (year)
Cemetery or crematory: F.H. Lincoln
Location: Bladensburg Rd at D.C. Line.

18. Funeral director: Gudbuds & Sellers.
Address: 254 Carroll St. Takoma Park, D.C.

19. Sept 9" 1946 James Seery
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 8 1946, at 10:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1936 to Sept 8 1946
and that I last saw h. E.R. alive on Sept. 7 1946

Immediate cause of death	DURATION
Cardio-Vascular-Renal disease	10 yr.
Due to	
Due to	
Other conditions: Aged & infirm	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Wm. A. Shannon M.D. M. D. or other
Address 113 Carroll St. N.W. Wash. D.C. Date signed 8-8-'46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

09256

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince Georges

City or town Hyattsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, Institution, or street address where death occurred: Veterans Chapel and Agar Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Hyattsville (If outside city or town limits, write RURAL and give nearest town)

Street No. East West Highway (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Daniel Williams

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	unknown

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: Years: about 65 ? | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace unknown (Town, county, and state)

10. Usual occupation Watchmaker

11. Industry or business

FATHER — 12. Name unknown

FATHER — 13. Birthplace unknown

MOTHER — 14. Maiden name unknown

MOTHER — 15. Birthplace unknown

16. Informant Edwin Bowden

Address 2311 North 9th Street Arlington Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 25 1946 (month) (day) (year)

Cemetery or crematory Evergreen

Location Bladensburg Md

18. Funeral director F Gasche Sons

Address Hyattsville Md.

19. Sept. 25 1946 (Date rec'd by registrar) Mrs Jas Severe Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1946 at 11:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Uremia	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results: See above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Deputy medical Examiner James D. Boyd M. D. or other

Address Forestville Md Date signed 9-15-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-A)

09257

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Prince Georges
City or town: Hall
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DEceased:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Halls
(If outside city or town limits, write RURAL and give nearest town)
Street No. On Gardner Edelen Farm
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Helen Pearl Windsor

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	married.

6.(b) Name of husband or wife: Maurice Windsor
6.(c) If alive, give age: 46 years

7. Birth data of deceased (mo., day, yr.): Feb 2, 1903

8. AGE: Years: 43 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Croome Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER
12. Name: Wade Butler
13. Birthplace: Maryland

MOTHER
14. Maiden name: Rose Newmen
15. Birthplace: Maryland

16. Informant: Maurice Windsor
Address: Halls, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9 23 46 (month) (day) (year)
Cemetery or crematory: Mt Carmel
Location: Upper Marlboro Md

18. Funeral director: Ritchie Brothers
Address: Upper Marlboro Md

19. Sept 21 1946 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 19 1946, at 10 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Acute Pulmonary Edema
Due to: Congestive heart failure
Due to: Cardiovascular Renal disease
Other conditions: 8 months pregnant

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] Deputy medical Examiner M. D. or other
Address: Westville Md Date signed: 9-19-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-a

CERTIFICATE OF DEATH

09258

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos., 7 days
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 2 mos., 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 821 - 7th St. N. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: CHARLIE G. WOODY

3.(b) Social Security Number: 577-28-5541

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: May D. Woody (dec.) 6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): October 1, 1902

8. AGE: Years	Months	Days	If less than one day
43	11	11	____ hrs. ____ min.

9. Birthplace: Knoxville, Tennessee
(Town, county, and state)

10. Usual occupation: Bus Boy

11. Industry or business:

FATHER
12. Name: Jeff Woody
13. Birthplace: Tennessee

MOTHER
14. Maiden name: Mary Grubbs
15. Birthplace: Tennessee

16. Informant: Decedent
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept 12, 1946 (month) (day) (year)

Cemetery or crematory:
Location: to Lenoir City, Tenn.

18. Funeral director: Albert Lasche
Address: 64th St N.E Wash. D.C.

19. Sept. 12, 1946 (Date rec'd by registrar) Rowland L. Phibbs Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: SEPTEMBER 12, 1946, at 6:35A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 5, 1946, to SEPT 12, 1946
and that I last saw h[illegible] alive on SEPT 12, 1946

Immediate cause of death	DURATION
Carcinoma of the Esophagus	9 mo.
Due to:	
Due to:	
Other conditions: Pulmonary Tuberculosis	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 9/12/46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0925 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale- RURAL
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs., 6 mo's, 6 days
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 4 yrs., 6 mo's, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Dist. of Columbia County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1306- V. Street, N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: -

3. (a) FULL NAME: SAMUEL YOUNG

3. (b) Social Security Number: 577-12-8880

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Beatrice Young
6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): June 1, 1907

8. AGE: Years	Months	Days	If less than one day
39	3	15	..... hrs. ..... min.

9. Birthplace: ?, Texas
(Town, county, and state)

10. Usual occupation: janitor

11. Industry or business: -

FATHER
12. Name: Oscar Young
13. Birthplace: unknown

MOTHER
14. Maiden name: Katherine Moss
15. Birthplace: unknown

16. Informant: decedent
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 16, 1946 (month) (day) (year)
Cemetery or crematory: Harmony Cemetery
Location: Washington, N.E., D.C.

18. Funeral director: Johnson & Jenkins
Address: 2053 Georgia Ave N.W.

19. Sept 16, 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: SEPTEMBER 16 1946 at 6:50A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MARCH 10 1942, to SEPT. 16 1946
and that I last saw h... i.M. alive on SEPT 16 1946

Immediate cause of death: PULMONARY TUBERCULOSIS — DURATION: 6 yrs 7 mos.
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 9/16/46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.